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INCLUDING SYPHILIS

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXXVI—No. 12 DECEMBER, 1918 WHOLE No. 433

Original Communications

PEMPHIGUS: A CLINICAL STUDY

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The present paper pretends nothing beyond a report of thirty cases of pemphigus treated in the wards of Mt. Sinai Hospital during the past five years (Table 1). No special investigations have been made directed toward a solution of this unfortunate dermatologic enigma, but the clinical facts to be reported have been correlated in the hope that we, or some of our readers, may pick up a clue to future enlightenment. We shall not review what has so often and so well been described, the lesions themselves, but shall devote our space to aspects of the disease, on the whole neglected in the literature. Neither shall we epitomize the literature, for the essence thereof is merely a confession of ignorance and a monument to futile effort.

CLASSIFICATIONS OF PEMPHIGUS

The conventional classification includes benign and malignant pemphigus, and acute and chronic varieties of the former, indeed perhaps of both. Furthermore, in both groups are pemphigus vulgaris, foliaceus and vegetans as well as combinations of these. The last statement is not generally accepted as a fact, the three types being considered distinct. As will be shown, however, this assumption is inaccurate. It is the result of overrefinement that so many distinctions have crept into use, for actually it must be known to any one con-

*Read before the Section on Dermatology, American Medical Association, Chicago, June 14, 1918.

TABLE 1.—CLINICAL STUDY OF THIRTY CASES OF PEMPHIGUS TREATED—

Case	Sex	Age	Nativity	Type	Initial Lesion	Duration on Admission	Temperature, F.	Clinical Course	
								Lesions	Result: Died in
1	F	65	American	Vulgaris	Mouth	6 weeks	100-102	Blebs on body	2 weeks
2	M	56	Russian	Vulgaris	Scalp	16 months	Normal	Blebs on body, scalp, conjunctivae, mouth	7 weeks
3	F	40	Russian	Vulgaris	Mouth	4 months	103	Body and mouth	2 months
4	M	65	Italian	Vulgaris	Body	3 weeks	Normal	Body	9 days
5	F	32	Russian	Vulgaris and vegetans	Face	4½ months	101-102	Axillae, groin, scalp, mouth	16 days
6	F	68	Russian	Vegetans	Scalp	3 months	Normal	Skin, mouth	19 days
7	F	51	Austrian	Vulgaris	Abdomen	7 weeks	Slight fever	Body	3 months
8	M	49	Russian	Vulgaris	Nose and mouth	1 year	None	Body	3 months
9	F	48	Roumanian	Vulgaris	Body	2 weeks	104	Body, mouth	6 months
10	F	52	Austrian	Vulgaris	Mouth	3 months	Normal	Body, lips, tongue, groin, pharynx	2 months
11	M	21	Russian	Vulgaris	Mouth	5 weeks	Slight	Body, mouth, nose	3 months
12	M	22	German	Vulgaris	Mouth	4 months	Normal	Body, mouth	5 months
13	F	53	American	Vulgaris and vegetans	Mouth alone 3 months	4 months	Normal	Body, mouth; lost 56 pounds in 3 months	3 months
14	M	62	Russian	Vulgaris	Face	2 months	Normal	Body	7 weeks
15	M	73	Russian	Vulgaris	Mouth	6 weeks	Normal	Admitted for cancer; esoph. had pemphigus; tongue, pharynx, larynx, conjunctivae. Readmitted 5 months later	8 months
16	F	25	Russian	Vulgaris	Mouth	3 months	Normal	Mouth, skin, conjunctivae,	5 months
17	M	52	Austrian	Vulgaris	Mouth, throat	3 months	Slight rise	Mouth, skin	3 weeks, 1 day after transfer
18	F	62	Russian	Vulgaris	Mouth	4 weeks	Normal	Mouth, skin	1 year, suicide
19	F	52	Hungarian	Foliaceous	Scalp, chest, abdomen	1 year	99–101	Nikolsky blebs; scales body	6 months
20	F	42	Russian	Vulgaris and foliaceous	Chest	5 months	101-103	Blebs mouth, foliaceous body	2¼ years, still alive
21	F	63	Austrian	Vulgaris	Mouth	10 weeks	.....	Body, mouth	17 weeks
22	M	62	Russian	Vulgaris	Mouth	5 weeks	99-100	Body and mouth	2 weeks
23	M	40	Russian	Vegetans, foliaceous	Groins, axillae	11 weeks	100-102	Axillae, groins	5 days
24	F	43	Russian	Vulgaris	Mouth	8 weeks	99-101	Mouth, 8 weeks; body, 2 weeks	5 days
25	M	30	Austrian	Vulgaris	Mouth	5 months	Normal	Mouth, skin	2½ months
26	M	21	Austrian	Vulgaris, vegetans	Mouth	3 months	Normal	Body, mouth, axillae	17 days
27	F	25	American	Vulgaris, vegetans	Mouth	6 months	99-101	Mouth, 6 months; groins, umbilicus, 5 weeks	10 weeks
28	F	48	American	Vulgaris	Mouth	7 weeks	Normal	7 weeks; mouth after 3 weeks, later on body	3½ months
29	F	50	Roumanian	Vulgaris	Mouth	2 months	Normal	Began with dysphagia, mouth, body	Still alive
30	M	41	Hungarian	Vulgaris	Chest	3 months	Normal	Improved on adrenalin, although when admitted appeared in extremis: 7 weeks in hospital	7 weeks, died suddenly

—DURING THE PAST FIVE YEARS AT MT. SINAI HOSPITAL, NEW YORK

Clinical Course	Pathologic Findings		Therapy
Total Duration	Blood	Special	
8 weeks	Normal	None	One arsphenamin (salvarsan) injection.
18 months	W.B.C., 16,000; poly., 79%; lymph., 19%; eos. 2%	None	Three arsphenamin (salvarsan) injections.
6 months	W.B.C., 13,900; poly., 79%; lymph., 19%; eos. 2%	None	Three arsphenamin (salvarsan) injections.
1 month	None	None	Two quinin infusions; intravenous
5 months	W.B.C., 16,000; poly., 65%; lymph., 32%; eos. 3%	None	Nine quinin infusions; intravenous
3½ months	None	None	Four quinin infusions; intravenous
5 months	W.B.C., 8,100; poly., 82% lymph., 18%; with fever 48,600	None	Three autoserum; 10 quinin; 3 neoarsphenamin (neosalvarsan) injections.
1¼ years	None	None	Ten quinin injections
6½ months	Poly., 62%; lymph., 25%; eos., 12%	None	Arsenic, 3 neoarsphenamin (neosalvarsan), 2 quinin injections
5 months	W.B.C., 15,000; poly., 60%; lymph., 39%; eos. —	None	Two emetin injections
4 months	W.B.C., 8,200; poly., 68%; lymph., 30%; eos., 2%	None	Two arsenobenzol; autoserum, staphylococcus vaccine, 20-200 million; roentgen rays. Temporary improvement with autoserum
9 months	W.B.C., 13,000; poly., 70%; eos., 30%	None	Quinin, roentgen rays, autoserum, emetin. Improvement with all, always relapse
7 months	W.B.C., 8,000; poly., 60%; lymph., 30%; eos., 10%	None	Emetin, arsenic, colon irrigations, lipoids by mouth
3½ months	Normal	Blood culture negative; abscess left axilla; Strep. hemolyticus; Temp. 101-104	Twelve quinin infusions
9½ months	W.B.C., 10,800; poly., 70%; lymph., 30%	None	Four arsphenamin (salvarsan) injections improved mouth lesions. On readmission emaciated; 5 arsphenamin (salvarsan) and autoserum injections without benefit. Transfusion, Unger method, better, relapse
8 months	W.B.C., 10,000; poly., 68%; lymph., 30%; eos., 2%	None	Autoserum, arsphenamin (salvarsan), improved under quinin. Worse after fourth injection
4 months	W.B.C., 8,000; poly., 65%; lymph., 32%; eos., 3%	None	Quinin infusions and blood transfusion 460 c.c., Unger
13 months	W.B.C., 12,000; poly., 56%; lymph., 42%; eos., 2%	None	Six arsphenamin (salvarsan) injections; mouth improved; recurrence body; 3 more salvarsan without benefit
18 months at another hospital	W.B.C., 11,000; poly., 68%; lymph., 30%; eos., 2%	None	Quinin infusions and Fowler's solution
Still alive	Normal	Feces normal	Remissions and relapses. Adrenalin, morphin, colon irrigations, etc.; emaciated; now on Dr. Whitehouse's service, Skin and Cancer Hospital
5 months	W.B.C., 8,000; poly., 37%; lymph., 31%; eos., 32%	Stool, colon bacillus; acute parenchymatous nephritis; ulcer duodenum at necropsy	Colon irrigations; autogenous vaccines, colon bacillus 50-800 million
1¾ months	None	None	Codein
12 weeks	W.B.C., 14,000; poly., 80%; lymph., 20%	Wassermann negative	Codein
9 weeks	None	None	Codein
7½ months	W.B.C., 21,000; poly., 65%; lymph., 26%; eos., 9%	None	Three intravenous injections gelatin (Epstein); severe immediate reactions; died 2½ months; temperature 104; edema of esophagus and face
3½ months	W.B.C., 13,600; poly., 84%; lymph., 14%; eos., 2%	None	Cacodylate
8 months	W.B.C., 21,500; poly., 71%; lymph., 29%	None	Three arsenobenzol, 2 typhoid vaccines intravenously, 8 autoserum. Temperature to 104 after vaccines
5 months	W.B.C., 13,200; poly., 67%; lymph., 32%; eos., 1%	Necropsy, enlarged suprarenals, liver; spleen small	Four intravenous injections of 1 per cent. proteose 1¼ to 2 cm. Arsenic no effect.
.....	W.B.C., 12,000; poly., 63%; lymph., 37%	None	Three arsenobenzol
5 months	W.B.C., 15,000; poly., 64%; lymph., 32%; eos., 1%	None	Three arsenobenzol; suprarenal extract, 15 minims injected hypodermically t. i. d.

versant with the facts through wide experience that the types are often mixed, or go over one from the other most capriciously. Neither is the prognosis in one type better or worse than in another. Actually, pemphigus foliaceus is the result only of large flaccid epidermolytic blebs rather than that of smaller bullae. Pemphigus vegetans is the result of maceration and proliferation of lesions in body folds in a manner analogous to what takes place in syphilis when flat condylomas form. No justification exists for artificial distinctions based on type pathologic responses to generic influences. Such reasoning always serves to complicate and confuse rather than to clarify.

TABLE 2.—FREQUENCY OF THE OCCURRENCE OF THE TYPES OF PEMPHIGUS

Types	Sex			Initial Lesion						
	M.	F.	Total	Mouth	Mouth, Nose, Throat	Scalp	Face	Body	Axillae, Groins	Total
P. vulgaris	11	11	22	14	2	1	1	4	..	22
P. vulgaris with foliaceus	0	1	1	..	..	..	..	1	..	1
P. vulg. with vegetans	1	3	4	2	..	..	2	..	..	4
P. foliaceus	0	1	1	..	..	..	..	1	..	1
P. vegetans	0	1	1	..	..	..	1	..	..	1
P. folia. with vegetans	1	0	1	..	..	..	..	..	1	1
Totals	13	17	30	16	2	1	4	6	1	30

PEMPHIGUS IS A CLINICAL ENTITY HAVING VARIOUS PHASES

It is submitted, then, that so far as can be ascertained at all, pemphigus in all of its phases is one disease. All may go over into one another or coexist. All of them inevitably are fatal, and in this respect the disease differs from others, the lesions of which simulate it. The imitators are dermatitis herpetiformis, erythema bullosum, urticaria bullosa, vaccinia and their subvarieties. Suffice it to say that none of these are fatal save the bullous dermatitis described by Engman and Mook which follows vaccination and which in its behavior suggests and may throw some light on pemphigus. Of impetigo herpetiformis and herpes gestationis, regarded as variants of Duhring's disease, the same may be stated.

THE MOST COMMON TYPE OF PEMPHIGUS

A perusal of Table 2 reveals that the bullous form, known as pemphigus vulgaris, is the commonest variety. Of thirty cases, twenty-two were of this type, while pemphigus vulgaris was associated with foliaceous lesions but once, and vegetating lesions four times. Foliaceous and vegetating pemphigus, in their pure forms, occurred once each and were associated once. Thirteen males and seventeen females were afflicted. It is striking that eleven of each sex had pure pemphigus vulgaris, while of the rarer forms six were in women and

only two in men. Only adults presented the disease, six in the third, three in the fourth, seven in the fifth, six in the sixth, seven in the seventh and one in the eighth decade. Excepting one Italian, all of the patients were Hebrews from southern Europe or whose ancestors came thence. Fourteen were born in Russia, six in Austria, four in the United States, two each in Roumania and Hungary and only one in Germany.

TRAUMA AS A PREDISPOSING ETIOLOGIC FACTOR

The onset of the lesions (Table 2) was prevailingly on buccal mucous surfaces. In sixteen instances the mouth was first involved, in two the mouth and throat, in one the scalp, in four the face and in seven the body. Thus twenty-three cases began on areas of the body exposed to trauma, that is, the nasopharynx, head and face. Whether this is significant or not only time will disclose. In this connection it is not out of place to mention a lawsuit following a death from pemphigus which developed after dental manipulation. One patient (Case 28) acquired the disease after tooth extraction. The dentist is being sued and the case will shortly come to trial, the patient's family deposing that he was responsible for her death. This is an example of the *post hoc ergo propter hoc* fallacy. Unquestionably, the sequence of events was a coincidence, but it is peculiar to the human mind, as pointed out by Bacon, to dwell on affirmative and neglect negative evidence. In two patients the conjunctiva was involved, albeit not with the initial lesion. A case seen at the Post-Graduate Hospital, and not included in this series, began with the picture of essential shrinkage of the conjunctiva and several years later presented the classic picture of pemphigus vulgaris.

HIGH MORTALITY OF PEMPHIGUS

Save for three patients, one of whom committed suicide and two of whom are now under observation, all died. Of these two, one patient (Case 29) has been ill only two months, while the other (Case 20) has had pemphigus foliaceus and vulgaris for two and one-half years. She is under Dr. Whitehouse's care having at first been treated by one of us (Highman). Of the twenty-seven fatal cases (Tables 3 and 4), seventeen died within six months, seven more between seven and ten months and three between the eleventh and eighteenth month. Death results mainly from cachexia, occasionally from pulmonary edema and never from any direct manifestation that might explain the disease. From these facts it appears fair to assert that pemphigus is invariably, and in all of its forms, fatal. It may

further be permissible to dogmatize to the extent of stating as a corollary that that which appears to be pemphigus and is not fatal is not actually pemphigus. This view is offered in full cognizance of allegations to the contrary in the literature.*

TABLE 3.—DURATION OF LIFE IN TWENTY-SEVEN PATIENTS WHO HAD PEMPHIGUS

Months	Died	Still Living	Suicides	Total
1	1			
2	3			
3	2	1 patient		
4	5			
5	5			
6	1			
7	2			
8	2			
9	1			
10	2			
12			1	
15	1			
18	2			
27		1 patient (Case 20)		
Total	27	2	1	30

TABLE 4.—SUMMARY OF THE DURATION OF LIFE IN THE CASES UNDER OBSERVATION

Months	Cases	Months	Cases
1 - 3	6		
4 - 6	11	1 - 6	17
7 - 9	5		
10 - 12	2	7 - 10	7
13 - 15	1		
16 - 18	2	11 - 18	3
Totals	27		27

FEVER AND LEUKOCYTE COUNT IN PEMPHIGUS

Other interesting features of the disease are found in observations on the temperature and leukocyte count. The temperature was not recorded in two cases. In the other twenty-eight (Table 5), there was no fever in fifteen cases, and a slight rise in five, while in five more it ranged from 101 to 103 F., and in three from 103 to 104. In one patient in the last group the temperature was normal until abscesses appeared in the axilla and returned to normal after these had been evacuated. Thus, in twenty-three of twenty-eight cases it may fairly be stated that there was no fever. When fever is present it is irregular, rises sometimes in the afternoon and sometimes in the forenoon, often appears when the rash is at its lowest ebb and vanishes with the bullous relapses. Thus pemphigus is in the main an afebrile or only slightly febrile disease.

* Since this paper was read all the patients have died.

TABLE 5.—TEMPERATURE RECORD IN THIRTY CASES OF PEMPHIGUS

Temperature	Number of Cases
Not recorded	2
Normal	15
Slight rise	5
101 to 102 F.	5
103 to 104 F.	3
Totals	30

LEUKOCYTOSIS OBSERVED IN THE SERIES OF CASES

The blood picture is also inconsistent. Examinations were made in twenty-four cases (Table 6). The leukocytosis exceeded 16,000 in only four cases; in eleven, it ranged between 11,000 and 15,000; in six, between 8,000 and 10,000. In three cases there was no leukocytosis, if the normal count be considered between 7,500 and 7,800. In only one instance was there a polymorphonuclear leukocytosis

TABLE 6.—RESULTS OF LEUKOCYTE COUNT IN THIRTY CASES OF PEMPHIGUS

Count	Number of Cases
Not made	6
Normal	3
8,000 to 10,000	6
11,000 to 15,000	11
16,000 to 20,000	2
21,000 to 30,000	2
31,000 to 50,000	1 with abscesses previously normal
Totals	30

above 70 per cent., and in only four an eosinophilia. In Case 9 (pemphigus vulgaris) there were 12 per cent. of eosinophils; in Case 13 (pemphigus vulgaris and vegetans), 10 per cent.; in Case 21 (pemphigus vulgaris), 32 per cent., and in Case 25 (pemphigus vulgaris), 9 per cent. Thus pemphigus tends to produce a moderate leukocytosis and in about one-third of the cases a polymorphonuclear increase. The eosinophilia appears to have no distinctive bearing on the condition. The erythrocyte count indicated the secondary anemia found in nearly all severe and wasting diseases.

OTHER CLINICAL OBSERVATIONS

Except in Case 21 in which there was nephritis, confirmed at necropsy, the urine was normal. In Case 14 a blood culture was made which proved negative. Such fecal examinations as were made and the one Wassermann test performed (in Case 23, pemphigus vegetans with lesions resembling flat condylomas) were negative. In Cases 21 and 28 necropsies were performed. The former presented a duodenal ulcer and parenchymatous nephritis; the latter enlarged suprarenal glands and liver and a small spleen. Necropsies are prevailingly negative in this disease, and it is particularly striking that this should be

so as regards the intestine. Since the disease so often begins in the upper part of the alimentary tract one necessarily expects involvement elsewhere therein.

TREATMENT

Therapeutically everything was attempted. Arsenic, arsphenamin (salvarsan), lipoids, proteose, vaccines, autoserum and quinin (Table 1) were employed, chiefly intravenously. Blood transfusions were made. All were without avail. The disease followed its capricious course, improving or getting worse, in no relation whatever to the treatment. Locally, roentgen rays, the Alpine lamp and all conventional remedies were employed with the same result. The patients finally died. Recently, based on Samberger's views, adrenalin was employed in Case 30. The patient seemed to be *in extremis* when admitted to the hospital and was nearly free from lesions after two weeks of this treatment when he suddenly died. Optimism based on transitory clinical improvement invariably receives this sort of shock. In Case 20 morphin and codein were at first used heroically on the assumption that if catabolism were suspended, the metabolic balance might swing in the patient's favor. She was clear of lesions in three weeks, attempted to sit up in a chair and the next day was covered with blebs; in three days more she again presented the classic and tragic picture of pemphigus foliaceus. Under Dr. Whitehouse's care she still lives, after two and one-half years of illness. She is emaciated and, although at times free of lesions, is nothing but an animated corpse. (See footnote.)

COMMENT

Pemphigus, then, is a disease occurring at all periods after adolescence, but chiefly between the ages of 40 and 70 (twenty cases out of the thirty in this series). It has nothing to do with pemphigus neonatorum, a confusing term sometimes applied to infantile impetigo contagiosa and sometimes to congenital syphilis. It seems to be slightly more frequent in women than in men, particularly in its rare forms. On the whole, it would appear that Hebrews are peculiarly vulnerable, and chiefly those who were born in, or whose immediate ancestors came from southern Europe. This may be erroneous since the majority of the patients at Mt. Sinai Hospital are of this origin, and pemphigus is certainly known in all lands. On the other hand, the impression conveyed in the foregoing is generally accepted, and racial predisposition to, or immunity against certain diseases is by no means rare. Trachoma and diabetes in Jews, keloid in negroes and goiter in the Swiss will serve as examples.

PEMPHIGUS IN ALL ITS FORMS BUT ONE DISEASE

The subdivision of pemphigus into its classical varieties and subvarieties is unphilosophical. There is no benign pemphigus. All those affected die. In 88 per cent. of the cases (Table 4) death occurs within ten, and in 60 per cent. within six months. Adjectives are relative, and, although the fatal end may be delayed, it is invariable; so that the term benign, as used merely in the sense of postponed death, is simply a cynical tribute to the inevitable. Neither is it sound to interdifferentiate pemphigus vulgaris, foliaceus and vegetans, as the last two are more frequently associated with the first than seen alone. There is thus no evasion of the probability that pemphigus in all its forms is one disease, the varieties representing but those excursions in aspect seen in many maladies. The constant factor is the mortality.

SUGGESTIONS AS TO THE ETIOLOGY BASED ON AUTHORS' CASES

No deductions can be made and very few inferences can be drawn from the foregoing as to the causes of the disease. The initial lesion appeared in the mouth in 60 per cent. of the cases and in 10 per cent. more on the head. Often an appreciable period is noted between the development of the first lesion and that of the general eruption. In Case 24 eight weeks elapsed; in Case 27, six months; in Case 28, seven weeks, and in the case with essential shrinkage of the conjunctiva, several years. It is difficult, in obtaining a history from the illiterate, always to secure a clear statement of facts or we would probably more often discover what appears to be an incubation period.

THEORIES AS TO THE ETIOLOGY DISCUSSED IN THE LITERATURE

The literature reflects that the cause of pemphigus has been regarded as infectious, allergic, metabolic and endocrinous. It is likely that the last hypothesis may be summarily dismissed. No metabolic disturbances have been consistently ascertained in pemphigus by any known methods. It is not associated with disturbed nitrogen nor sugar metabolism, nor have any examinations of the blood and spinal fluid for any other abnormal bodies revealed their presence. This may be due to limitations of method. Allergic and anaphylactic cutaneous diseases are urticaria and prurigo; pemphigus suggests neither, except bullous urticaria and erythema, but these are proverbially mild diseases. Nor is there any evidence of their relationship either in appearance, behavior or known causation.

PEMPHIGUS MAY POSSIBLY BE AN INFECTIOUS DISEASE

The infectious theory too has its great limitations. The disease is afebrile, but so often is tuberculosis, while syphilis almost always is. The blood picture certainly negates any pathogenic organism in the

streptococcus or pneumococcus group. On the other hand, the frequency of the onset in the mouth favors infection, and the fact that it may occur elsewhere is explicable by assuming that the infection is carried from the mouth to other parts of the body — a view by no means extravagant considering the uncleanly class of people usually affected. Let it be clearly stated here that the overworked theory of focal infection is not being invoked, for this hypothesis explains too much. Blood cultures in pemphigus have invariably been negative. Thus if it is an infectious disease, the causative agent is no known one. The pathogenic organisms in the exanthemas have not yet been demonstrated, and pemphigus may have a similar origin. Since its mortality is 100 per cent., such an organism would be more virulent even than that of variola, and since arsphenamin (salvarsan) does not control the disease it is probably not caused either by a spirochete or other protozoon, such as Lipschitz's *cytoplasma oviforme* which, in one of the patients in our series, was sought for in vain by Dr. Ottenberg. It is not unreasonable, however, to accept as a working hypothesis that the disease is infectious, and that since the initial lesion is usually buccal the home of the organism is the mouth. How it gets there, what predisponant favors its pathogenicity, what it is, are even more remotely speculative than the assumption of its existence.

PATHOGENESIS

The etiology is admittedly vague, but no less so than its pathogenesis. Many dermatologists, notably the French school, regard it as a syndrome rather than an entity, with distinct etiologic, pathogenic and pathologic criteria. They class it as an anatomic rather than a morbid entity. Hebra's school assume the opposite view, and the disciples of Besnier, principally Brocq, reject the Viennese doctrine. In fact, Audry of Toulouse declares: "A French physician is unable to understand a Viennese article on chronic pemphigus. In France we no longer accept this syndrome. It has long, and we think rightly, been dismembered."

It appears more justifiable to lean toward the Austrian concept, and this with the further elaboration of Samberger who conceives pemphigus as a bullous eruption on a normal base, caused by a hypersecretion of lymph with papillary and epidermal lymphedema. The bulla is not the result of cell degeneration, as in an inflammatory lesion, but to a mechanical separation of the cells. Thus it is caused by a quantitative and not a qualitative change in the lymph. The hypersecretion is in turn the result of overacting vascular endothelium in the papillary plexus. If sustained a serious effusion results, as well as bullae, and a soft oozing surface with loosened epidermis develops

(Nikolsky's sign). Thus pemphigus foliaceus and pemphigus vegetans cannot be regarded as clinical entities, but as subvarieties of one disease of which pemphigus vulgaris is the commonest form. In support of this the coexistence of the various phases may be reiterated.

SUMMARY

The views of the present writers may then be summed up somewhat as follows: Pemphigus is an essentially bullous disease, the lesions of which are occasioned by hypersecretion of lymph referable to overactivity of vascular endothelium. Whether the immediately responsible factor is an infection, or something else, cannot be stated; but, on general principles, the weight of evidence appears to substantiate the former view. In support thereof are the initial lesion chiefly on the buccal mucosa, the apparent incubation period, the leukocytosis, mild fever and invariably fatal termination. These features, together with the interassociation of all subvarieties of the disease, indicate that it is a clinical entity and no mere syndrome, and that the ancient resolution of the malady into several distinct forms is untenable.

TOXIC ERYTHEMAS AND THEIR BULLOUS MANIFESTATIONS *

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Bullous lesions as an expression of toxic erythemas are of more or less frequent occurrence and may offer great diagnostic difficulties. As they do not develop in every attack of such, nor often represent the sole symptom, but, as a rule, part of a combination of symptoms, these latter should also be considered. The vast subject of toxic erythemas cannot be treated at length, however, in the time and space allotted to this part. Nor shall there be included in the list all erythemas based on a toxic etiology. For this reason the large group of infectious diseases leading directly or indirectly to one or more types of exanthema, and presenting, together with these, outspoken clear types will be omitted altogether.

ETIOLOGIC FACTORS

As nearly all toxic erythemas show a close resemblance to each other and their symptoms do not offer any possibility of classification (except a few), the rational method is followed by dividing them according to their etiology. And thus two large groups will be discussed: (1) that in which the causative agents are substances ingested as food or certain chemical material formed within the body, and (2) the erythemas following the administration of drugs. To these will be added a brief consideration of urticaria, which is truly a toxic erythema, and of the serotherapeutic erythemas.

1. *Erythemas Caused by Foods.* — Certain apparently perfectly normal food substances do cause in some people a severe erythematous reaction; as for instance, strawberries, cheese, lobster, eggs and a host of others. And this occurs with certain regularity every time an individual partakes of the food to which he is susceptible. On the other hand, foods which have undergone some deterioration before being ingested containing ptomains or other toxic material, and normal foods acquiring toxic character in their passage through the gastro-intestinal canal, are frequently the cause of erythemas. The latter may also occur with various diseases, as nephritis, uremia, gout, diabetes, cystitis, uterine and ovarian affections, gastric dilatation, habitual constipation and many others.

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* Read before the Section on Dermatology at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

The cutaneous symptoms which are encountered as a result of these intoxications are of a polymorphous character, that is, they show various lesions. These may be urticarial, macular, papular, purpuric and bullous. A single type of these may comprise the eruption of an attack or there may be more than one. The most frequent are the urticarial, macular and papular, while the bullous lesions are of rarer occurrence, and then as a rule develop on the basis of others. The urticarial manifestations may be represented by either smaller or larger wheals or extensive plaquelike elevations; the macular, as a rule, in the form of a more generalized morbilliform eruption; and, lastly, the papular in smaller or larger irregular patches, discrete or confluent, or as a generalized scarlatiniform erythema. This last form is accompanied by a lesser or greater amount of edematous swelling and often gives rise to bullae. This is observed mostly in certain areas of the skin, as on the face, ears, hands and the outer genitalia, especially so in children. In rare instances of this class pictures of erythema multiforme are encountered.

2. *Erythemas Caused by Drugs.*—The reactive phenomena of the skin from the administration of medicinal substances present the truest class of toxic erythemas, because these substances are of a strictly known chemical composition and dose. The latter facts do not, however, determine the character of the cutaneous lesions, if such be produced. Therefore, a classification on the basis of difference in their chemical formula is in the great majority of cases just as little possible as it is on the strength of clinical difference of the lesions. One drug may produce various forms of erythema, while one and the same form or type may be produced alike by many. There are, however, typical pictures produced by some drugs, which permit to identify the same. The majority of drugs are apt to produce erythemas which correspond absolutely to those various forms excited by the toxic agents enumerated in Class 1. It would lead too far to consider all drugs which may act as toxic agents. For a closer study and complete review of this subject the excellent volume by Morrow[1] may be recommended.

Only a few drugs will be mentioned, those showing unusual manifestations, as we encounter them after the use of iodin, bromin and arsenical compounds and antipyrin which, however, may also produce all types of lesions as those from other toxic causes.

Iodin Compounds: These may produce a peculiar form of acne which occupies most frequently the locations of vulgar acne, or may be more generalized. The papulopustules of this acne show a greater intensity of inflammation and are, as a rule, larger and more sensitive

1. Morrow, P. A.: The New Sydenham Society, 1893, 143, p. 361.

than those of the vulgar form. These acneiform lesions may coalesce and form papillomatous, flat plaques or tumorlike aggregations, which are then most frequently situated on the face and extremities (iododerma tuberosum). The iodic acne is a nearly constant initial symptom of iodin intoxication and will frequently be helpful in the diagnosis, as will be the symptoms of the erythematous affection of the mucous membranes of the nose and mouth and the headache. The bullous eruptions may be generalized or appear as a symptom of a complex character resembling erythema multiforme. In this instance there may develop considerable swelling of the whole face, dorsa of the hands and forearms. Within these swollen areas are seen numerous bullous lesions with apparently clear or sanguinolent contents. Most of these bullae have not true fluid contents, but are pseudobullae. On incising them scarcely any serum exudes, but there is protruding a glassy, semi-solid mass, consisting of copious cellular elements. In the milder as well as in the severer types there may also occur pemphiguslike lesions on the oral and nasal mucosa. The intensive form is frequently accompanied by severe systemic symptoms and may lead to death. It is of peculiar interest that even small doses of the drug may bring about the most intensive cutaneous reaction. It has, however, been observed that the grave cases of iodic erythema occur in patients suffering from renal or cardiac insufficiency.

Bromin Compounds: These may cause various lesions, the bullous, however, are very rare. Most frequently the bromin acne is encountered which shows great similarity to that caused by iodin salts. These papulopustules show a great tendency to coalesce and form coinlike or irregular plaques, as also characteristic tumorlike formations, especially on the face, neck and anterior tibial surfaces (bromoderma tuberosum). Whichever other types of lesions may occur after the ingestion of bromin compounds, their nature and cause will be ascertained by the regularly simultaneous presence of the typical acne.

Arsenical Compounds: These may produce the symptoms common to the other erythemas. The characteristic changes, however, are the palmar and plantar keratosis and the melanosis. The latter may affect the integument as a whole, or only in parts, as the chest, back and those places which normally show deeper pigmentation. As a rule, this develops after long use of the remedy and its appearance should be a caution not to continue the use of the drug, which would otherwise increase the pigmentation. The condition resembles that seen in Addison's disease, is caused by the increase of the normal pigment of the skin and may remain stationary for years. It develops most frequently in places which previously have not been the seat of any lesions at all. The bullous manifestations may be represented by

zosteric eruption which does not differ from the usual picture of herpes zoster. While this latter condition may occur after shorter or longer ingestion, the bullous lesions of generalized distribution develop after long continued use of the drug. In some of these cases grave, general symptoms may also be present.

Antipyrin: This drug may cause eruptions which cannot be distinguished from those produced by various other toxic agents. These eruptions are, as a rule, more generalized in distribution. Of greater interest and importance are, however, the circumscribed or fixed forms. These consist of well-defined, slightly elevated erythematous, red, round disks or papular plaques, of sizes of the different coins; they are few in number — sometimes only one lesion is present — asymmetrically arranged and located quite distant from each other. Their places of predilection are the dorsum of a hand, wrist or forearm, gluteal region, lower part of the abdomen, external genitalia; rarely the face. These areas shortly change in color, becoming livid and then brown. The pigmentation remains for a certain length of time. Frequently bullae develop on these plaques, which transformation may occupy a part or the whole of them. Bullous lesions of limited distribution develop also independent of these, and they occur with preference on the dorsa of the hands and around the natural openings, that is, genitalia, around the anus and mouth, and also within the mouth. They show a tendency to rupture easily, leaving oozing surfaces, and in the mouth excoriations. These bullous remnants may give cause for diagnostic misunderstanding — they may, for instance, be mistaken for syphilitic lesions. After healing, pigmentation is noted, as it is in the plaquelike lesions. These circumscribed forms are very interesting because on repeated ingestion of the drug the very same places become affected in the same manner as before. Through repeated attacks the pigmentation, after healing, becomes more intensified, and these dark areas may remain *quasi* permanent for months and years.

Considerations of Urticaria

With true urticaria bullous transformation is exceedingly rare, and this is based on the anatomic conditions of the wheal. While there is considerable edema in the corium, the epidermis is nearly free from it. There are, however, two exceptions to this rule. The urticarial lesions after drugs may show bullous changes, as do the lesions of that form of chronic urticaria known as lichen urticatus or strophulus, observed in infants and in young children. Here are found various lesions, copious red spots, true wheals, nodes and small, flat angular urticarial lesions (resembling lichen planus papules). All these lesions

may readily assume bullous changes, as may bullous lesions occur independently of these. The disease is accompanied by intensive itching. Sometimes the bullous lesions are quite numerous and to such a degree predominant that at superficial examination other bullous affections might be suggested. On closer inspection, however, small angular papules will be found also, and thus the true nature of the disease disclosed. Lichen urticatus is mostly caused by gastro-intestinal derangements.

SEROTHERAPEUTIC ERYTHEMAS

The erythemas occurring after the application of therapeutic serums are in general not different from those enumerated in the preceding groups, although the urticarial and scarlatiniform manifestations are most frequently observed. The alien serum per se acts as a toxic agent.

DIAGNOSTIC FEATURES

Bullous eruptions of toxic erythema may offer some diagnostic difficulty. Any eruption of unusual character and distribution should arouse our suspicion as to a toxic cause. The usual presence of other types of lesions together with the bullous, and their sudden development should be cause enough to subject the patient to a thorough examination and to inquire as to a certain substance having been taken, or if previous attacks of like nature had occurred after the ingestion of such. Certain bullous forms, as the intensive cases from iodin compounds, arsenic and antipyrin, or those occurring in strophulus, may imitate other well known dermatoses. But the symptoms outlined before will typify them sufficiently.

The toxic erythemas have all a common anatomic basis and are expressions of inflammation; hyperemia, transudation and exudation. The edema may occupy the upper or all layers of the corium, as the epidermis. The bullous lesion represents the highest degree of intensity of the edema in the epidermis. In urticaria, as outlined before, the epidermis does not show any degree of edema as to cause bullous transformation. In two instances, however, it may take place in urticaria from drugs and in the chronic form in children, known as strophulus or lichen urticatus. Only one symptom of toxic erythema which does not develop on the basis of hyperemia is the melanotic discoloration of the skin after the use of arsenic. We see pigmentary changes in other toxic erythemas, but these are the results of the preceding exudation and consist of remnants of blood, while the pigmentation from arsenic represents an increase of normal pigment; it is melanotic.

IDIOSYNCRASIES

The question of the great susceptibility of some individuals to certain substances in developing erythema is very interesting, but as yet not fully answered. We see some persons react promptly on the ingestion of eggs or other albuminous substances, and this may occur with regularity even when the smallest amount is taken. The same holds true with some drugs, for instance, quinin. Once a person shows intolerance to it, a trace of it may suffice to produce an extensive rash.

SENSITIZATION

From our present-day knowledge of biologic phenomena we can explain the reactive symptoms after food substances and serotherapeutic serums as true expressions of anaphylaxis. The individuals thus reacting have become sensitized through and to alien albumin. A similar sensitization might take place with quinin. This condition of anaphylaxis does not necessarily exist throughout life. Some people may tolerate foodstuffs of all forms for many years, and suddenly one will produce an intolerance which may last for a longer or shorter time. In other words, this abnormal condition may be overcome, as it is acquired. It is further noteworthy that the sensitization of an individual to one specific substance may make him, to a certain degree, intolerant to toxic material of different composition. So we observe that if an individual is suffering from a toxic erythema from other causes than from a drug and intensive itching or burning is present, sedatives or hypnotics will give temporary relief of the latter, but after subsidence of their action the symptoms will be aggravated.

The greater or lesser intolerance to drugs and their reactive erythemas, which may be changeable with the same individual, cannot as clearly be ascribed to anaphylaxis, but may have a similar basis. All we know with certainty is that persons suffering from renal or cardiac insufficiency do not tolerate drugs as well as normal individuals, and this is especially true with the iodin compounds, but it may be explained on the ground of deficient elimination. The toxic substances developed within the body act in regard to the question of susceptibility according to their composition, either like albuminous or like other chemical substances.

FURTHER OBSERVATIONS

It is possible that various phenomena, not as yet understood, may form a common basis for the development of erythema from various causes. In the enumeration of the typical arsenical eruptions there was mentioned the melanosis, which bears great resemblance to the coloration in Addison's disease. This latter stands in close relation

to affection of the adrenals, as does pigmentation to this gland in a normal state. This suggests the possibility of some connection between ductless glands and the production of toxic erythema. We see further cutaneous changes, from thyroid defect (as in myxedema), from ovarian affection and in menstruation. The ductless glands, in close cooperation with each other, maintain to a certain degree the physiologic equilibrium. This may be disturbed through altered conditions in one or the other gland. Through certain toxic substances they may be influenced in their normal or altered state and be helpful in producing greater susceptibility and with it erythema.

CONCLUSIONS

1. Toxic erythemas are of frequent occurrence. The bullous manifestations are least frequently observed and then there are, as a rule, other lesions also present.

2. An eruption which cannot be placed as a well known dermatosis and develops suddenly should arouse suspicion as to a possible toxic cause.

3. In administering drugs, especially iodin compounds, it will be advisable to ascertain whether the patient is suffering from renal or cardiac insufficiency.

4. Inasmuch as most drugs are apt to produce erythema, caution must be used in administering sedatives and, more so, hypnotics for the relief of severe itching and burning accompanying toxic erythema. The drugs will relieve these symptoms temporarily, and with the cessation of the action of the drug, the same will be more intensified.

5. The increased susceptibility to certain foodstuffs and albuminous substances, which are produced within the body, may be explained as the result of anaphylactic sensitization. For drugs and nonalbuminous material ingested with decomposed foods or developed within the body, a similar phenomenon suggests itself. The question as to how much the ductless glands may have to do with the development of such susceptibility must be left to future investigation.

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ABSTRACT OF DISCUSSION ON PAPERS OF DRS. GOLDENBERG AND HIGHMAN, AND DR. LIEBERTHAL

DR. HENRY H. HAZEN, Washington, D. C.: I had the opportunity to study six cases of pemphigus and my conclusions were similar to those of Dr. Highman. In each of the six cases the primary lesion was found to be autoinoculable. Serum from a vesicle inoculated into the skin will produce new lesions. As a control we tried various substances, such as normal saline, mild proteins, so as to make sure that the lesions were not produced by irritation alone. In a number of instances we succeeded in inoculating new bacteria. A number of different organisms were isolated. In some cases there was the pseudodiphtheria bacillus, staphylococcus and pyocyaneus, and one or two could

not be identified in the scientific departments at Washington. We thought from this evidence that some cases of pemphigus may be due to infections. At the same time, I feel that when we say pemphigus we are including many cases of eruption that we cannot define definitely. In Dr. Highman's cases there can be doubt that that one disease was under discussion, but from the literature and textbooks I am sure the term pemphigus covers many conditions. In two or three of my cases I noted that the lesions apparently began as impetigo. I think Dr. Highman stated that the blood cultures were always negative; in one case we found the bacillus pyocyaneus both in the urine and in the blood.

DR. RICHARD L. SUTTON, Kansas City: Dr. Highman seems to have been particularly unforunate in coming in contact with a series of such serious cases of the disease. I think we can separate pemphigus into two groups of cases, the acute and the chronic. The acute, which is represented by the Pernet-Bulloch type, cases of which have been described by Bowen, Pollitzer and Grindon in this country, usually occurs in butchers and others of similar occupation, and often terminates fatally. The chronic type may again be divided into three distinct groups: Chronic, uncomplicated pemphigus, pemphigus foliaceus (which I believe to be chronic pemphigus plus a bacillus pyocyaneus infection), and pemphigus vegetans (which probably is chronic pemphigus plus a staphylococcus infection). Dr. Hazen's suggestion is an extremely interesting one. Rosenow found streptococci in the vesicles of herpes zoster, why not micro-organisms in pemphigus bullae?

DR. A. RAVOGLI, Cincinnati: In one case I think I made a mistake. I was called to see a patient who had a bullous eruption all over his body associated with severe general symptoms. My first impression was that it was a case of pemphigus. I have already established in my mind that pemphigus is the result of nephritis; the urine is neutral in reaction; there are albumin and casts present. In this case the urine was acid clear and negative. He had a bullous eruption. I kept on with the diagnosis of pemphigus, however. The patient died and the Industrial Commission offered to pay his indemnity. If I would have put down the diagnosis of pemphigus, the family would not have received a cent, but if I put down infectious bullous dermatitis he would have been paid. The man was caught between the doors of an elevator and had a severe excoriation on the calf of the left leg. This was neglected, it became full of crusts, and from there the dermatitis of infectious nature started, so I made a diagnosis of dermatitis bullosa septica following the trauma.

I believe that in pemphigus there are always the toxic elements of the urine which produce the peculiar bullae and the peculiar lymphatic edema. In pemphigus foliaceus, in some cases, it was difficult to give a subcutaneous injection, the epidermis could not be taken between my fingers to make the injection — it would come out. It is true that in the patients who die, the diagnosis of pemphigus seems right, while in the patients who get well the bullae are nothing else than an epiphenomenon. In one case of pemphigus foliaceus a little relief was obtained from endovenous injection of Fischer's solution.

I did not hear anything about epidermolysis bullosa. That is one of the most wonderful bullous eruptions we can ever see. It is stubborn, and when of hereditary type, is hard to bring to recovery. It resembles somewhat dermatitis herpetiformis, but it is on entirely different disease. Every time the patient received a little injury on the skin it produced bullae. The bullae follows a local edema; it seems to be nothing less than a true erythema from an unstable vasomotor condition, and this erythema produced by the slight trauma causes effusion of serum and bullae.

In reference to the paper of Dr. Lieberthal, there is no doubt that toxic erythemas have their origin from a toxic condition of the system, and this very likely is caused by faulty elimination from the kidneys. When the function of the kidney is normal enormous doses of iodid of potassium will not produce

any trouble; in other patients in whom the elimination through the kidneys is not active, 5 or 10 grains of the drug may produce a bullous eruption and toxic erythema. Erythema bullosum follows the touching of the skin with toxic sumac and other plants which have irritating properties. A poor fellow had dermatitis venenata from *Rhus toxicodendron,* first on both legs and then all over the body; bullae covered nearly the whole body. It was nothing else than a toxic erythema.

DR. JOHN A. FORDYCE, New York: I recently observed several cases of dermatitis herpetiformis which point to focal infections as a possible eiologic factor. One patient presented typical lesions of dermatitis herpetiformis with intense itching. I suggested that a roentgenogram be taken of the teeth. This was done and several apical abscesses revealed. The teeth were removed and the skin lesion rapidly improved and finally disappeared Another patient had suffered for many years from a recurring bullous eruption which was also intensely pruritic. His teeth were in bad condition. He was sent to a dentist who made a culture from the secretion about the gums and found the *Streptococcus viridans.* Several teeth were removed, followed by a great intensification of the skin trouble. Since then all of the diseased teeth have been removed and the eruption has shown a considerable improvement. It has not disappeared entirely. I can confirm the observations of Dr. Highman as to the failure of any local or general treatment in controlling pemphigus vegetans; two such cases are now under my care and in both the lesions are proving refractory to any method of treatment which I have been able to employ.

DR. MICHAEL L. RAVITCH, Louisville, Ky.: I have seen few cases of bullous eruptions, one of pemphigus and dermatitis herpetiformis and a few of erythema multiforme at Camp Zachary Taylor. It is a peculiar thing that when the pneumonia was at its height we found most of these cases, and when the pneumonia had subsided the skin reactions did not make their appearance. I could not draw a distinct line between true pemphigus and erythema bullosum, but there is no question but that those patients who died must have had a true pemphigus, and I have no doubt but that all these cases were of an infectious nature. When I am accepted in service I will study these cases further, and will have a better opportunity to give you a better report.

DR. H. G. IRVINE, Minneapolis: The rôle of focal infection in these diseases is exceedingly interesting, but we will have to withhold judgment for some time before we can decide that focal infection is actually the cause of them. I had one case of dermatitis herpetiformis of several years' duration which was under observation for two years. It was a case with all the earmarks of a toxic etiology. The gastro-intestinal tract, teeth and tonsils were examined. The tonsils were undoubtedly infected and were removed. The man improved remarkably and I presented him before the Minnesota Dermatological Society with practically no lesions within two or three weeks of the removal of the tonsils. Two or three months later the lesions recurred with more severity than ever before. Since that time the condition has continued, being sometimes better and sometimes worse. The improvement from the removal of the tonsils was only temporary.

DR. JESSE B. SHELMIRE, Dallas, Texas: Four years ago an old gentleman came to me with an eruption of the face and hands which gradually spread over the entire body. Various diagnoses were made by dermatologists of Kansas City, St. Louis and New York. In the end it proved to be a case of dermatitis herpetiformis. This diagnosis was made by Dr. Engman. After suffering four years, with little relief at any time, his teeth, which were in a very bad condition, were given attention, and from that time he commenced to improve. It has now been about six months since this focal infection was cleaned up, and he is now almost free of any trouble and has been able to attend to his business again.

Dr. Philip F. Shaffner, Chicago: About two years ago I saw a particularly severe bullous eruption in a young child with a very pronounced involvement of the mucous membranes. The tonsils were enormous and we decided to have them removed. Within a few days after the removal of the tonsils the eruption cleaned up entirely. Perhaps it is not the focal infection per se that causes the trouble, but the diseased tonsils or teeth may furnish an atrium of infection.

Dr. Samuel E. Sweitzer, Minneapolis: I have studied the etiology of the pemphigus and dermatitis herpetiformis group considerably. An old gentleman had a pemphigus of a rather acute type. We advised that the teeth be extracted one by one, thinking it best to try to remove the infection by the slow extraction rather than by rapid removal of the teeth. But the old gentleman had the teeth extracted all at once. Following this he had a very severe infection and died. We thought that if one focus of infection was removed at a time, at intervals of several days, it would have been better. We have examined these cases from all angles, and in every hospital patient we have taken out the tonsils and extracted the teeth, but so far we have not had any results. The patients have the same relapses, whether there are bad teeth and tonsils or not in a dermatitis herpetiformis.

Dr. Everett S. Lain, Oklahoma City: It is gratifying to hear such men as Dr. Highman and Dr. Fordyce speak well of focal infections. Dermatitis herpetiformis was one of the first diseases I studied in 1913 and 1914. Within the last few months I have again taken up a clinical study of this disease. My experience has been similar to that of others. I have seen a marked remission in many cases after removal of foci of infection. In some cases there have been recurrences, but nothing like the previous ailment. In some of these cases a surgeon has subsequently found an infected gallbladder or appendix, which may still account for a focal infection being the etiologic factor.

Dr. Joseph Zeisler, Chicago: It is just twenty-five years since I was commissioned by the late Dr. Morrow to write the chapter on pemphigus in his "System." At that time I made a very careful study of the bullous eruptions, and since then my interest in the subject ever remained keen and alive. It is a very remarkable acknowledgement to make that very little real progress has been made in these twenty-five years in our knowledge of pemphigus, and that we practically stand still on the same ground occupied at that time. Even the modern views concerning the relationship of focal infection to these eruptions are of small help to clarify the atmosphere.

A few points stand out clearly, as they have before. In the first place, the mere presence of bullae does not constitute pemphigus. If this were so, bullous eruption from iodids or from vesicants would be a pemphigus. Secondly, the character of the bullae determines their clinical importance. I am sure you all agree with me that a bullous eruption in which the blebs are firm and dense is as a rule, benign. If they are flaccid and break easily, they denote malignancy. Therein we have the distinguishing points between pemphigus vulgaris, which is often curable, and pemphigus foliaceus in which we are almost always helpless to arrest the fatal termination. A few years ago I presented before this association a report of a group of cases of apparent pemphigus which were all due to infection with some kind of a meat poison. All of the cases occurred either in butchers or in persons who had to do with meat products. Within the last few weeks I observed another case of this kind in a man who spends a good part of the day in a butcher shop. He developed an intense bullous eruption on his face and hands which was easily relieved by keeping him away from his place of occupation.

Another point and a therapeutic suggestion: The curable cases of pemphigus are still best managed by the two great remedies, arsenic and quinin. We have tried in our practice, occasionally, the injection of autoserum, but have seen no benefit from it.

Concerning the question of dermatitis herpetiformis, I still feel that it is a distinctly benign eruption with an underlying involvement of the nervous system. I have not the slightest doubt that all cases of dermatitis herpetiformis owe their origin to some deep impression on the nervous system.

DR. WALTER J. HIGHMAN, New York: We have had a series of thirty cases of pemphigus in the last few years at Mount Sinai Hospital, eight of which were examples of the rare forms and twenty-two of which were pemphigus vulgaris. Of these twenty-two cases, all the patients died. I think the only case of pemphigus that survived over two years was a case of pemphigus foliaceus, and that patient is dying. As to diseases related to pemphigus — the other forms of bullous eruption — we stated that we were not defining them now or presenting a thesis. We are trying to subdivide this vast group into various subgroups so that we will have a tangible working basis. We do not know that it is correct to isolate pemphigus. We do know that some of the related groups are mild and some severe, just as in any other disease. We know that there is one group of cases which runs a mild clinical course, although it ends fatally, and this is the group which I would be tempted to call pemphigus, whether acute or chronic.

Contrary to Dr. Ravogli's experience, I have never found any renal involvement, except in one case. I have never found anything at necropsy, and neither has any one else, so far as I know. Unquestionably there are conditions that look like pemphigus in which you can get a positive blood culture. Perhaps, all cases will show this when we know the proper method of isolating the organism. It may be an anaerobic organism or a protozoon.

In a case which I diagnosed clinically as pityriasis rubra of Hebra, I made an unfavorable prognosis. The man had been sick for two years. He had bad teeth and thinking that he might have the additional comfort of a clean mouth, his teeth were extracted and he recovered. Since then we have been pulling enough teeth to satisfy even Cadmus, but they have all kept their dermatitis exfoliativa. I had a patient who had thousands to waste and he wasted them on a dentist. Immediately afterward he developed dermatitis herpetiformis. I think that tooth abscesses, septic tonsils, or theoretically, even one streptococcus — if you may recognize one streptococcus — tucked away in a tonsil or appendix may be an etiologic factor. Is every disease due to a focal infection? When we apply focal infections to such diseases as dermatitis herpetiformis, which is self-limited and comes in groups, we have to think very carefully and very slowly and perhaps not so enthusiastically as our friend from Kansas City.

DR. DAVID LIEBERTHAL, Chicago: I subscribe to everything Dr. Highman said. Within the last twenty-five years I have seen many cases of pemphigus and have learned not to make a diagnosis until absolutely sure of my ground. I have never seen a patient afflicted with pemphigus recover. Therefore, when I make a diagnosis of pemphigus I feel justified in giving a bad prognosis also.

RETENTION CYSTS OF THE MUCOUS MEMBRANE OF THE LIP*

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While it is probable that cases of simple retention cyst of the labial mucosa are more frequently encountered in the practice of dermatology than in any other branch of medicine, the condition has never been described, so far as I know, in any of the standard textbooks on diseases of the skin. In a few treatises on surgery, and particularly in those dealing with the injuries and malformations of the mouth, the disorder is mentioned, but as a rule only casually.

RECENT OBSERVATIONS BY THE AUTHOR

My attention was first attracted to the affection about four years ago, and since that time I have seen eleven typical examples. Brophy[1] speaks of the frequency with which the lesions occur in cases of harelip, but in none of my own patients was this deformity present.

Anatomically, the structures principally affected are the ducts of the labial glands (Sebastian[2]). These organs, which are in reality diminutive salivary glands, vary from 0.5 to 1.5 mm. in diameter, and from 40 to 60 or more in number. They are located just beneath the mucosa, where they can be felt as small, shotlike bodies. When the lip is everted, and carefully dried with a soft cloth, mucus can be seen exuding in dewlike drops from the tiny orifices of the ducts. These canals are also the ones which are involved in cheilitis glandularis apostematosa.

The excretory ducts are lined with a single layer of cylindric epithelium. The character of the contents of the cysts is dependent on the changes which have taken place. As Virchow,[3] in speaking of mucous cysts in general, has said:

> The contents usually are twofold, mucous and epithelial cells. If the epithelial cells are very numerous, the fluid contents assume a cloudy appearance. The epithelium does not always correspond with the epithelium which

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* Read before the Section on Dermatology at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

1. Brophy: Oral Surgery, Philadelphia, P. Blakiston's Son & Co., 1915, pp. 847 and 1058.

2. Sebastian: Recherches Anatomiques, physiologiques, pathologiques, et semeilogiques sur les glands labiales, Groningen u. Bremen, 1842, cited by J. B. Murphy, Clinics, 1916, 5, p. 220.

3. Virchow: Die Krankhaften Geschwülste, 1863, 1, p. 236.

was previously present. The more the sac broadens out, the more the character of the epithelium is altered, as a rule; and, while in the beginning one finds in the sac the same epithelium as was originally present — pavement epithelium where there was pavement epithelium, cylindric epithlium where there was cylindric epithelium, ciliated epithelium where there was ciliated epithelium—it may later happen that one finds pavement epithelium alone, where previously cylindric or ciliated epithelium was present.

Traumatic and displacement cysts, while fairly common in this locality (Speese and Skillern[4]) do not come within the scope of the present paper.

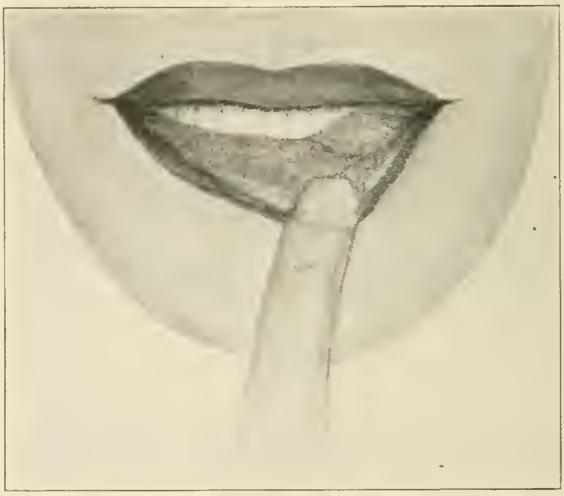

Fig. 1.—Clinical appearance of a simple retention mucous cyst of the lip.

CLINICAL APPEARANCE

Clinically, simple retention cysts of the mucous membrane of the lip vary in size from that of a pinhead to that of a small hazelnut. The most common location is the lower lip, at a point overlying the left cuspid tooth. The lesions are somewhat paler than the normal mucous membrane (owing to the character of their contents and to pressure), and are painless. Frequently their presence is discovered only through accident. When they are incised, a whitish, glairy, ropy fluid escapes. If the opening is allowed to close, the cyst promptly refills.

Of the eleven cases under my observation, nine occurred in men. In every instance the lower lip was the one involved, and in seven of the eleven cases the lesion was opposite the left lower cuspid teeth.

4. Speese and Skillern: International Clinics, 2, 27th S., p. 256.

Fig. 2.—Showing the histopathologic structure of a simple retention mucous cyst of the lip. Low magnification.

TREATMENT

Brophy recommends incision, evacuation, and the application of tincture of iodin, or oil of cassia, or cauterization with zinc chlorid (15 per cent.), or phenol, followed by alcohol. In the milder cases, the employment of one of these measures generally suffices, but frequently it is necessary to resort to more radical measures, and entirely remove the offending lining membrane. In my experience the best plan is the removal of the sac *in toto* under novocain anesthesia. Skillern's[5] method of nerve blocking may often be employed in these cases with highly satisfactory results. Following excision, the wound should be closed with horsehair or fine catgut sutures. In this way the amount of ensuing scar tissue is reduced to the minimum, and the possibility of ultimate development of degenerative or malignant changes at the site of the former lesion greatly lessened.

ABSTRACT OF DISCUSSION

DR. WILLIAM ALLEN PUSEY, Chicago: I have seen many of these patients, and it is surprising how often they come with a mistaken diagnosis. These cases are mistaken for initial lesions of syphilis and not infrequently for epithelioma, though, of course, they bear only the slightest resemblance to either of these troubles. There is one causal factor which Dr. Sutton did not mention, and that is traumatism. That is a frequent cause. They are, as Dr. Sutton says, quite intractable. Opening them and cauterizing with such caustics as iodin, phenol or silver nitrate is invariably followed by recurrence. Even thorough cauterizing with chlorid of zinc will often fail to cure them. I have treated them for the last few years by cauterizing them with actual cautery. A few drops of 2 per cent. novocain solution makes this quite painless. The cyst is emptied after incising, and the cavity is thoroughly cauterized with a small point cautery. It produces a cavity which looks quite formidable, but which heals with practically no scarring, and the results are permanent. The whole procedure can be done in a few minutes, and it is much more simple than excising and stitching together.

DR. JESSE B. SHELMIRE, Dallas, Tex.: Twenty-two years ago my first cases of this nature came under observation. Two patients came then, and on looking up the literature I could find nothing in the works on dermatology or in any of the recent textbooks on surgery. In Ashhurst's "Surgery," printed many years before this, I found a few lines concerning this disease. I have had the same experience in opening and cauterizing these cysts that Dr. Pusey had. Now, I never attempt to treat them, except by complete excision, and I have had twenty or more cases in the past twenty-two years.

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5. Skillern: On the Blocking of Infra-Orbital and Mental Nerves at Their Foramina to Induce Operative Anesthesia in Their Cutaneous Distribution, Surgery, Gynecology and Obst., 1914, 18, p. 387.

Society Transactions

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, April 23, 1918

JAMES C. JOHNSTON, M.D., *President*

FIBROSARCOMA OF THE FINGERS. Presented by DR. WISE for DR. FORDYCE.

David H., aged 9 months, a healthy and robust child, presented pea-sized, globular, indurated, subcutaneous swellings on the backs of the first and second joints of two fingers of the left and three fingers of the right hand. They were of about seven months' duration. The skin over them was at first tense and pale, later becoming inflamed and edematous. A lesion of the ring finger of the right hand became ulcerated, and amputation at the second joint was performed. Biopsy revealed fibrosarcoma. The other lesion will receive roentgen-ray treatment.

DISCUSSION

DR. FORDYCE said that clinically he would not have thought the condition to be sarcoma; histologically, it would be difficult to differentiate between fibrosarcoma and fibroma. It did not suggest sarcoma to him. It was a unique case, and he did not know what to call it.

DR. HEIMANN said that he did not know that he could have made a clinical diagnosis of the case, but did not think he would have called it tuberculous. The infant was only 2 months old when the condition appeared, and tuberculosis in any form was extremely rare in infants under 1 year of age. If previous to the eruption the child had had an attack of measles, tuberculosis might be considered, and in any case syphilis was to be excluded though it had not the lesions of syphilis. The lesions were hard, more like fibroma or some other neoplasm; but in spite of this fact he doubted whether he would have made the diagnosis clinically which was indicated histologically.

NEVUS CEREBELLIFORMIS (SOFT MOLE). Presented by DR. WISE for DR. FORDYCE.

The patient, a girl, aged 16, presented a group of large, soft moles on the right buttock. They were said to have appeared five years ago, but the mother admitted that for a number of years previously she had felt subcutaneous tumors at the sites of the moles. The lesions gradually assumed tumorlike proportions, but were unaccompanied by subjective sensations.

On examination the upper and inner quadrant of the buttock presented three large masses together with several smaller satellite tumors. The surface of the moles was somewhat pink in color, the skin was smooth and velvety, and thrown into folds and ridges, resembling the convolutions of the cerebellum. They were attached to the underlying tissues by a broad and pedunculated base and were easily movable. Biopsy revealed the structure of a lymph-angiofibroma of the soft nevus type. The patient was referred to the hospital for surgical removal of the growths.

DISCUSSION

DR. MACKEE said that the histology was interesting. The epidermis was normal. In the upper part of the derma there was no collagen or at least no collagenous bundles, although there was a delicate network of connective tissue that stained very faintly. The lymph spaces were markedly dilated, and there were large numbers of young connective tissue cells. The tissue resembled that seen in soft fibroma—it also suggested myxomatous tissue.

DR. SHERWELL said that it resembled cases of xanthoma that he had seen, but it was evidently not that from the biopsy report. He had, however, seen two or three instances of very pronounced tumors in that region which were xanthomatous lesions.

DR. TRIMBLE said that he agreed with the diagnosis, of course, but it was a very unusual tumor. Once before he had seen one instance in the same locality, but could not recall the scientific name. This name had just been recalled by Dr. Fordyce "cerebelliform." It seemed to offer a very fine field for operation by the general surgeon, and it was rather surprising that some one had not attempted to remove it surgically.

DR. HEIMANN said that he did not see why this lesion should be called a nevus at all, as it had been present for only five years, unless one interpreted the term nevus in a very broad way. From the histologic description given by Dr. MacKee, and from a glance at the slide with the naked eye, the picture suggested a soft fibroma. It was very common to find myxomatous tissue in lesions of this type.

DR. MACKEE told of a case in which a lesion on the back of a girl's neck presented the same clinical picture as this one; it had the same soft type and color. It was treated with CO_2 snow and disappeared entirely; but two or three years later the patient developed a sarcoma and died in three months.

SCLERODERMA TREATED BY PITUITRIN. Presented by DR. TRIMBLE.

About two years ago the patient had about fifteen or twenty morphea lesions on the abdomen and breasts, also one the size of the palm of the hand over the sacrum. She was put on pituitrin, her toleration not exceeding 1 grain three times a day; most of the time she was given only ½ grain three times a day. Under this treatment she made an excellent recovery, and at the time of presentation there were only two or three very small pigmented lesions remaining over the sacrum. During the treatment she had severe headaches and nose bleed occurred on several occasions, and the dose had to be decreased.

The speaker said that he had several other similar cases in the clinic at the same time, all of which had been given the same drug without noticeable effect. They were dispensary patients, and did not continue treatment for any great length of time.

DISCUSSION

DR. HEIMANN said that it was interesting actually at last to see a case in which improvement had taken place under pituitrin. In the generalized type of scleroderma he had never seen improvement, even when the treatment had been maintained over long periods of time—for the greater part of a year.

DR. SHERWELL said that he had been particularly interested in the case since he had been one of the first to advocate the use of pituitrin in various skin affections, notably psoriasis. Dr. Johnston's case (which had been his originally and had been transferred to Dr. Johnston on account of propinquity of abode) to which Dr. Trimble had referred, received tremendous doses—15 or 16 grains three times a day without any adverse symptoms. She had been under the same treatment, not such large doses, however, in the speaker's hands. The case was generalized scleroderma, the worst he had ever seen, the disease affecting at least half the body and the limbs; the face badly and symmetrically affected; the hands and arms up to the shoulders, etc. The condition was especially

marked toward the extremities of the lower limbs, the skin being hard and ivorylike. Before the patient came under his care she had been treated by several physicians without beneficial result. The pituitrin treatment benefited her to an appreciable extent, the face softened somewhat and the arms improved, but the future was problematical and it seemed doubtful if further improvement would accrue. Dr. Johnston had so treated the "white spot" affection and other cases with effect. The speaker said that he had used pituitrin a great deal in psoriasis with remarkable results, especially in cases of overfatty children; in some patients it proved to be the only remedy, and they had recovered and remained well for two or three years. This matter (pituitrin treatment) had been brought up at a meeting of the American Dermatological Association by the speaker some three or four years since, and he had then spoken of using it in connection with psoriasis.

DR. TRIMBLE said that he had wanted particularly to bring out the point that out of five patients treated with pituitrin this was the only one that had shown any improvement. There were two cases of sclerodactylia in which it had been administered over a long period with no improvement whatever; two others were beautiful cases of morphea, but no control could be exercised over them, and they did not take the treatment regularly. None of the patients could take over one-half grain comfortably, and the best he could do was to give 1 grain three times a day. Anything above that produced the constitutional effect of the drug—severe headaches, nosebleed, etc.

LUPUS ERYTHEMATOSUS (NODULAR TYPE). Presented by DR. WISE for DR. FORDYCE.

Mrs. H. H., aged 45, was in good health and presented numerous patchy lesions of lupus erythematosus on the cheeks, brows and ears. The lesions on the cheeks consisted of a series of circular, raised, distinctly infiltrated and edematous nodules, arranged in circinate form, the center showing only a little inflammatory reaction without palpable infiltration. At first glance the plaques resembled a nodular syphilid. The other patches, those on the ears and eyebrows, were typical scaly lesions. The Wassermann reaction was negative. Biopsy of one of the nodular lesions revealed the characteristic structural changes of lupus erythematosus.

DISCUSSION

DR. MACKEE said that the histology explained the presence of the nodules. There was the usual amount of infiltration, and, in addition, an enormous amount of edema. The edema also explained why the nodules of lupus erythematosus were rather transient.

NEVUS VERRUCOSUS. Presented by DR. WISE for DR. FORDYCE.

K. K., woman, aged 26, presented a xanthomalike, flat, warty lesion on the occipital portion of the scalp. The area was about 1 inch in diameter and the surface was hard and rough to the touch. The lesion had been present since birth. At the posterior edge of this patch was a tab of granulating, moist, soft tissue, attached by a pedunculated ribbonlike pedicle to the periphery of the warty growth. This had existed only since the past two or three weeks. The patient gave a history of trauma from a hat pin.

DISCUSSION

DR. HEIMANN thought it was a wart, and that one end had become infected.

DR. MACKEE said that it appeared to be a granuloma, but that it had sprung from the nevus; one should, therefore, consider the possibility of sarcoma.

MULTIPLE PIGMENTED SOFT NEVI AND VERRUCAE PLANAE. Presented by DR. WISE for DR. FORDYCE.

H. E., married, a negress, aged 59, had been treated for chronic eczema of the upper extremities and trunk for several months. Since the past four months the patient stated that numerous small growths had made their appearance on the face and neck, unaccompanied by subjective sensations. On examination the right side of the neck presented several dozen soft and hard growths, deeply pigmented, varying in size from a pinhead to a pea, and resembling ordinary moles. On both cheeks were a large number of pinhead sized, well-defined flat warts, similar to verrucae juvenilis in appearance.

TUBERCULOSIS VERRUCOSA CUTIS (?). Presented by DR. MACKEE for DR. FORDYCE.

The patient was a man, aged 35, an elevator operator. The eruption consisted of dull red, palm-sized verrucous and vegetating lesions on the cheeks, neck, chest, and dorsa of the hands. There was some suppuration and exudation. According to the history, the first lesion developed on the cheeks three months before the patient came under observation. There was a distinct tendency toward spontaneous healing with scarring. The speaker said that several diagnostic possibilities would have to be considered, but he thought the two diseases that would have to be most carefully differentiated were blastomycosis and tuberculosis. Against tuberculosis was the short duration, rapid evolution and involution. On the other hand, the small amount of exudation, edema, pustulation, together with the markedly irregular scars, suggested tuberculosis. The scarring was exactly like that seen in scrofuloderma. The patient was seen for the first time on the day of presentation, so that there had been no time for investigation.

DISCUSSION

DR. FORDYCE did not think a positive diagnosis could be made without the aid of a microscope.

DR. TRIMBLE said that the fact that the lesion on the hand was dry, and that the patient had lesions on the side of the neck that resembled scrofuloderma, would lead him to think that it was tuberculous. Of course, other affections could not be ruled out without further study. The lesion on the wrist was suggestive of scrofuloderma.

DR. WHITEHOUSE thought it resembled tuberculosis more than anything else, but a biopsy would clear up the matter.

DR. HEIMANN said that all agreed that it was one of three conditions. If it were tuberculosis, it would be more disseminated; if blastomycosis, it would be the Gilchrist form; in favor of sporotrichosis was the tendency to spontaneous involution, and the tendency to lymphatic vessel involvement, as seen on the wrist. That, however, might also be true of blastomycosis. In his opinion, the first two to be ruled out were blastomycosis and sporotrichosis. On the clinical evidence it seemed more like sporotrichosis than any suspected case seen in the last five years.

DR. WISE favored the diagnosis of tuberculosis for the entire process.

CASE FOR DIAGNOSIS (RAYNAUD'S DISEASE?). Presented by DR. WISE for DR. FORDYCE.

The patient was a man, aged 38, married, a native of Russia. He had been treated at the Vanderbilt Clinic for the past six months, without showing improvement. He presented a bluish-red, congested, perniolike appearance of the hands and feet, and complained of great pain in the feet after walking short distances. In addition, he had recurrent attacks of erythema nodosum, some of the nodose lesions being present on the feet and legs when exhibited.

These lesions would disappear spontaneously and were slightly tender to pressure. The diagnosis of beginning Raynaud's disease was suggested. The treatment with massage, electricity, dry heat, etc., had proved unavailing. Several Wassermann tests were negative, and the history as to syphilis and gonorrhea was negative. He was presented with the hope of obtaining suggestions as to treatment.

DISCUSSION

DR. LANE was inclined to make a diagnosis of early Buerger's disease (thrombo-angeitis obliterans). The symptoms were fairly typical. In some cases syphilis was probably the etiologic factor, and a negative Wassermann reaction in this case of course did not rule out the presence of that disease. The fact that the patient suffered pain after walking a short distance was not conclusive but was rather suggestive of Buerger's disease.

DR. TRIMBLE said that, as one of the speakers remarked, every time they were confronted with a case like this three or four processes come up for consideration. In days gone by this case would have been considered erythromelalgia. If the patient had symmetrical gangrene, it would be called Raynauds disease. Since he had no gangrene, it could not be called that. It was certainly a vascular process, and that was about as far as any one could determine. The clinical features were quite distinct; although these cases were rare, they were encountered now and then, and every case had exactly the same clinical symptoms, with perhaps some difference in degree; pain in the foot, and the dusky redness, that this man had. The condition was more frequently unilateral than bilateral; the main difference was that some cases had more cyanosis than others. This might be accounted for by the fact that in some cases the veins and the arteries were both affected. The speaker said that he had seen three cases within the past year; two were private patients examined in consultation, in whom the diagnosis was complete so far as it could be made. One patient had a negative Wassermann reaction; the other gave a positive test. Of course, many physicians concluded that the condition was a syphilitic endarteritis as soon as they heard of the positive Wassermann test. Another case was the counterpart of this one, with a small area of gangrene on one of the small toes. This latter case was shown at one of the meetings of the Society, and continued to progress. That patient had a ++++ Wassermann reaction, and was treated with salvarsan and mercury, none of which caused any improvement. The condition progressed until an amputation at the knee joint became necessary. Weir Mitchell first called attention to the condition many years ago, and being a neurologist, he thought that the nervous system was in some way at fault. As said before, the clinical syndrome was always the same, and we might as well retain the name given to it by Weir Mitchell, until we learned something more about the condition. Regardless of the cause, the clinical picture was the same.

The prognosis was bad, and Dr. Heimann had outlined the treatment very well, only it would be of no value. The man would never have any relief unless some better knowledge about the condition could be found. It would either progress and eventually come to amputation, or it might remain about as at present for an indefinite length of time. He had never seen a case that was benefited by any treatment. There was no use trying to find a new name for the condition; better call it erythromelalgia and let it go at that, until we know more about the disease.

DR. LANE did not think that this case, nor that Buerger's disease, could be classified as erythromelalgia. In erythromelalgia there was pain and burning even when the feet were elevated, the condition was often relieved in cold weather, the arteries showed good circulation and sometimes throbbed visibly, while in Buerger's disease there was usually lessened arterial flow, and frequently total obstruction as the disease progresses.

DR. TRIMBLE said that Dr. Lane had spoken mainly of the subjective symptoms, which were liable to be different in a series of cases at different times. Some new subjective symptoms may have been noted since Weir Mitchell described the condition, which might cause some different term to be applied to it.

BLASTOMYCOSIS. Presented by DR. WISE for DR. FORDYCE.

H. C., man, aged 40, a paper hanger by occupation, presented himself, April 19, with a lesion occupying the entire dorsal surface of the right hand. The disease was of five months' duration. The lesion consisted of a raised, sharply defined, reddish yellow, doughy plaque, the surface densely studded with large pinhead-sized, papular excrescences, closely set together and bathed in a more or less viscid film of pus. Smears revealed the presence of blastomyces, and histologic examination of a piece of tissue showed the usual structural changes of the affection.

DISCUSSION

DR. TRIMBLE said that even though the lesion was covered with ointment. one could see through the ointment, the moisture, which in these cases was a good clinical diagnostic point.

CASE FOR DIAGNOSIS (NEUROMA ?). Presented by DR. WISE.

N. Y., man, aged 34, was referred to the speaker by Dr. Brenner. The lesions had been present since birth. The right arm, dorsal surface, and the forearm over the radial surface, presented a large number of papules varying in size from a barley corn to a pea. These papules were closely set together. Their color varied from a bright yellowish brown to a distinct brown tint on the upper arm; on the forearm, the papules were generally reddish pink in color and were closely grouped. In consistence, most of the papules were firm and indurated. Pinching one of them between the fingers elicited a sharp twinge of pain. The surface of the lesions was quite smooth and free from scabs. The left leg anteriorly presented several dozen smaller lesions and there were a few isolated pea-sized papules elsewhere, one on the left hip and one on the inner surface of the left thigh above the knee. A report of the biopsy findings will be presented at the next meeting.

DISCUSSION

DR. TRIMBLE said that he would not offer a diagnosis except for the remark that the patient had had the lesions all his life. It resembled a neurofibroma. It was very clearly depicted in one of the textbooks.

PARAPSORIASIS EN PLAQUES. Presented by DR. HEIMANN for DR. SCHWARTZ.

The patient was a man, aged 55. The eruption had been present five years, was confined to the lower extremities, did not itch, and consisted of very superficial, sharply defined patches of a pale red color, covered with a fine white scale.

DISCUSSION

DR. HEIMANN told of a recent case of parapsoriasis in which the plaques were distributed like those in Dr. Schwartz' case. The patient was a man about 50 years of age, who had had the condition for twelve or fifteen years. Then two or three of the lesions began to itch, etc., and the condition made the speaker wonder whether it was going to develop into mycosis. A week later it was a well developed case of dermatitis herpetiformis. Dr. Goldenberg saw the case, and they both came to the conclusion that it was dermatitis herpetiformis in conjunction with an old parapsoriasis.

GUMMA OF PENIS. Presented by DR. WISE for DR. FORDYCE.

J. S., aged 46, a negro man, was married but had never had children. He appeared at the clinic on the day of presentation, so that the speaker was unable to report with regard to microscopic and serologic tests. He denied ever having had a chancre. The lesion on the penis was of about six weeks' duration and consisted of an ulcer which implicated the greater portion of the glans, extending upward and involving the entire corona and sulcus, as well as the anterior portion of the prepuce. The ulceration was about one-half inch in depth; the edge was sharply defined, somewhat rolled, indurated, and hypertrophic. The interior of the ulcer was occupied by a ragged looking mass of necrotic, foul smelling, purulent material. There was no inguinal adenitis. The lesion was only moderately painful. The general health of the patient was fair.

DISCUSSION

DR. MACKEE thought that the possibility of local gangrene, gangrenous balanitis, or chancroid, should be considered in spite of the absence of inguinal adenitis.

DR. TRIMBLE said there would be an immense amount of adenitis with a chancroid of that extent.

CLINICAL REPORT

NAIL CYSTS. Presented by DR. FORDYCE.

DR. FORDYCE reported a condition which had come under his observation and which he had not found described in any of the textbooks, namely, cysts on the terminal phalanges near the base of the nails. They were tense and whitish in color, and on incising them the substance that exuded resembled half coagulated white of egg. The only interpretation that he could offer was that the matrix of the nail was injured and the imperfect nail formed a cyst. It could be cured by curetting and applying some substance which acted like iodin. Two patients were cured by such measures, but a third was not benefited. Some of the cysts were as large as a pigeon's egg.

DISCUSSION

DR. TRIMBLE said that so far as he could remember the nearest approach to the condition described by Dr. Fordyce was the synovial cysts of the skin, occurring at times on the distal phalanges near the joint.

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, May 27, 1918

CHARLES MALLORY WILLIAMS, M.D., *President*

CASE FOR DIAGNOSIS. Presented by DR. WINFIELD.

The patient, a 7-months-old baby, first came under observation six months ago. Two weeks after birth an eruption appeared on the head, arms, legs and feet. It was warty in character, highly inflamed, and later became pustular. When first seen by the speaker the lesions resembled vegetating dermatitis, although some of the spots suggested bromoderma. A simple antiseptic ointment cleared up the pustular condition. The patient then passed from observation until a few days ago. The eruption was still warty. The lesions tended to linear formation; they were situated on the heel and ankle of both feet, on the left arm, on the right hand, and on the left side of the head. There was no inflammation, but pressure on the lesions caused the child to cry out.

CASE FOR DIAGNOSIS. Presented by DR. WISE.

H. P., a man, aged 45, of American birth, presented an eruption which started about three years ago. It consisted of numerous crusted and impetiginous plaques, some of them presenting greasy scabs, scattered on the chest and back, varying in size from a quarter to 1 inch in diameter. In addition, there were many pigmented areas on the back, shoulders and abdomen, the sites of preexisting lesions. The scalp presented a typical seborrheic eczema. The patient stated that most of the lesions were preceded by blisters, which broke soon after their inception, resulting in the crusted spots. He also noted that slight traumatisms would readily provoke superficial excoriations of the skin (Nikolsky's sign). The disease at first resembled an ordinary seborrheic eczema, but gradually changed its appearance and assumed an impetiginous character. Itching was slight. The lesions persisted since the past two years, despite the most energetic treatment.

On the day of presentation, several flaccid bullae were noted on the arm and trunk, thus supporting the diagnosis of pemphigus or possibly epidermolysis bullosa.*

DISCUSSION

DR. HEIMANN said that the flaccidity of the bleb was not against the diagnosis of pemphigus, for the tendency of these blebs is often to be short-lived. The grouping and crusting, and all the other clinical features—excepting the fact that as yet there was no lesion in the mouth—were all in favor of pemphigus; and the presence of Nikolsky's sign indicated pemphigus foliaceus. From a series of cases studied at Mt. Sinai Hospital, the speaker said he was inclined to think that the designation of the different types of pemphigus was artificial. Of the 30 cases studied, 22 were styled pemphigus vulgaris; 8 were either pemphigus foliaceus, or vegetans, etc. One case had an association of foliaceus and vegetans. Watching the clinical course of all these cases, it was found that they passed from one type to another in a very capricious manner, so that a case that came on with one type might develop the characteristics of another and then lapse into the former. Microscopically, there was no doubt that this case was pemphigus. The anatomy was certainly not that of Duhring's disease.

DR. TRIMBLE said that if he was not mistaken he had seen this case before. The fact that the man had blebs and had pemphigus, brought out an interesting feature. When this case was shown at the Academy of Medicine some time since, he was inclined to think the diagnosis was easy, although at that time a number of diagnoses were made—one being lichen planus. At that time he thought the condition was a seborrheic keratosis developing on an eczema, and said then that one might term it a keratosis senilis developing on a seborrheic eczema. Evidently that was a mistake, as the man had since developed blebs. Three years ago at the Skin and Cancer Hospital they had a patient with lesions on the chest and back in the location for seborrheic eczema that greatly resembled this when first seen. A salve of salicylic acid and sulphur was prescribed, but without benefit; on the contrary, the salve seemed to irritate the condition, and two or three of the lesions appeared white and examination revealed a small amount of fluid in the lower part of the lesion; the man had pressed them, and developed a typical pemphigus foliaceus. The man died in the hospital, within six months after admission. When first seen the condition was that of a typical seborrheic eczema, but after the pustular condition developed the patient became worse rapidly.

DR. WINFIELD said that the case to which Dr. Trimble had referred was that of a patient of his own who had what was supposed to be seborrheic eczema and later developed blebs. At one time he became very much better;

*A biopsy confirmed the diagnosis of pemphigus.

the seborrheic condition cleared up and he disappeared from observation. Later his family reported that he was in the Skin and Cancer Hospital. He had very much the appearance of this patient when first seen, excepting that his eczema was much worse.

DR. MACKEE agreed with what Dr. Heimann had said. The case was undoubtedly pemphigus and would probably turn out to be pemphigus foliaceus.

DR. WISE agreed with the diagnosis of pemphigus.

DR. TRIMBLE, referring to Dr. Wise's remarks about the duration of pemphigus, said that in his experience pemphigus foliaceus lasts a very long time. He had not seen a great many cases, but they had all lasted at least two years. There was now in the Skin and Cancer Hospital a patient who had pemphigus foliaceus who had been there three years. The condition was almost universal, and the patient became worse and then better. He was not confined to his room, but walked about the hospital. Of course the outcome was inevitable. Patients with other forms of pemphigus died after a fairly short course.

DR. HEIMANN said it was true that pemphigus foliaceus proved fatal later than other forms, but five patients in a series of thirty cases died within six months. One case had persisted for two and a half years; this was first studied at Mt. Sinai Hospital and then went to the Skin and Cancer Hospital and was under Dr. Whitehouse's care. The speaker said he did not think it a wise choice of words to apply the term "benign" to such cases; the end was only delayed.

DR. SHERWELL considered it an exceptional form of dermatitis herpetiformis. In comment on the conclusions of several of the members as to the always fatal issue and rapid course of the disease in question, he cited a patient whom, about forty years ago, he had brought to the attention of the Society and afterward had presented the patient in an improved condition. At the time, the patient was a child, a little girl of German parentage living in Brooklyn. The case was published in full in the *Archives of Dermatology* for January, 1877. Perhaps there never was a case more exactly bearing out in all respects the classic description of the disease by Cazenave and Biett. The patient was now a woman and married, but had no children. She had had several relapses in the course of the past years, each perhaps less typical as time went on. The speaker said that he had attended her for one of these relapses last fall, when she presented bullae—flaccid, with the buttermilk-like content form—all over the superficies of the body, on the tongue and fauces; the lesions drying on the body and falling off in immense quantities, so that when the patient stood erect, or as nearly so as she could, the surface around her resembled an ill-swept hearth. The speaker referred the members to the original report which he had cited, and said that he had photographs of the patient which he would show at a subsequent meeting of the Society. Probably Dr. Fox and some of the other older members would recall the case.

DR. G. H. FOX said he remembered the case referred to by Dr. Sherwell, and said that a picture of it was published in the *Archives of Dermatology*. It was a typical case of pemphigus foliaceus, but the patient did not die. It was the only case he had ever known that did get well.

MYCOSIS FUNGOIDES. Presented by DR. SHERWELL.

Mr. S. R., aged 39, came to the office on May 10 with a generalized eruption of somewhat milder grade than as when presented, the treatment applied having apparently benefited him. Its first appearance was about four years ago and occurred in the fold of the right arm; later it appeared on the back, then in and around the groins, and then became generalized over the trunk and extremities—never on the face or scalp. There was never any appearance of eczematous or other discharge, only a slight furfuraceous

desquamation at any time. The subjective symptoms consisted of a moderate amount of pruritus, occasionally intensified. The lesions gradually increased—not rapidly—remaining for a considerable time of the same size, without improvement under medical treatment. The patient had been under the care of four physicians at various times, and was at the Polyclinic last year. The speaker asked for confirmation of his diagnosis and for suggestions as to further treatment. He had given the patient a lotion of which the active elements were bichlorid of mercury, salicylic acid, emulsion of bitter almonds, and dilute hydrocyanic acid; also, internally, the iodids and arsenic, and an antirheumatic and tonic mixture. The pruritus had ceased, and there was a decided improvement in the livid and slightly raised lesions, the centers decidedly clearing.

DISCUSSION

DR. WISE agreed with the diagnosis, which was accepted without dissent by all the members.

CASE FOR DIAGNOSIS. Presented by DR. WISE for DR. FORDYCE.

A. L., a woman, aged 18, single, was referred to the Vanderbilt Clinic from the Presbyterian Hospital with a diagnosis of favus of the leg. The lower portion of the left leg, anteriorly, presented a lesion of two and a half years' duration. It consisted of an irregular, red, slightly ulcerated, indurated area, about 3 inches in diameter, full of scales and studded with several small excoriations containing pus. The general appearance was that of erythema induratum. The bacteriologist at the Presbyterian Hospital had made a microscopic examination of the secretion on the surface of the lesion and had reported finding the favus mycelium. On presentation no evidence of favus was visible. Above the original lesion were several smooth depressed scars, resembling those of syphilis or of Bazin's disease. The patient had had over a dozen Wassermann tests, all of which were negative. A microscopic examination of a piece of excised tissue was under way.

DISCUSSION

DR. LANE felt very sure it was not favus. The diagnosis seemed to lie between Bazin's disease and syphilis. He thought the therapeutic test for syphilis would probably settle the diagnosis promptly.

DR. HEIMANN said that clinically it was a case of erythema induratum.

DR. WINFIELD said he would have to test the case therapeutically before attempting to make a diagnosis.

CASE FOR DIAGNOSIS (SARCOID OR LUPUS ERYTHEMATOSIS). Presented by DR. TRIMBLE.

The patient was a man, aged 34. The skin affection was limited to the face, and the duration was three years. On close questioning, the patient said that on one or two occasions, the affection had disappeared, only to return after a short period of freedom. The condition consisted of several semi-nodular lesions, on both cheeks. The exact location was over the malar bones and they were more numerous on the left side than the right. The color was dusky red with a livid hue. They were distinctly nodular, though not hard.

DISCUSSION

DR. WINFIELD favored the diagnosis of sarcoid.

DR. HEIMANN said that on the whole he was inclined to favor the diagnosis of sarcoid, but he had seen a case originating as this one did and developing into lupus erythematosus. The more he saw of these border line cases the more confused he becomes as to how to classify them.

DR. LANE agreed with Dr. Heimann that the more one saw of these cases the more confusing became the classification and the more uncertain the clinical diagnosis. One feature that seemed to disagree with either diagnosis was the fact that the lesions came out and disappeared so rapidly. The man stated that they came on in a week or two and then disappeared as quickly for considerable periods. The appearance was certainly more like sarcoid than lupus erythematosis.

DR. GILMOUR said he saw the case some time ago. Dr. Johnston also saw the case. They did not think it was lupus erythematosus, but as it came and went they made a diagnosis of erythema multiforme.

DR. MACKEE favored a diagnosis of lupus erythematosus, basing the contention, however, largely on the history. In lupus erythematosus there were at times acute exacerbations when the lesions became nodular on account of the marked, deep-seated, circumscribed edema. Such nodules were evanescent, however, and in two or three weeks they would flatten down spontaneously.

DR. TRIMBLE said that he had seen the patient for the first time that afternoon, and from the color and appearance of the nodules he was inclined to think the condition was sarcoid; the diagnosis of lupus erythematosus was, however, to be considered on account of the localization of the lesions. The sarcoids that he had seen were not bilateral and symmetrical. They may have been on both sides but were not symmetrical, like those on the man's face. On these two points he had made a tentative diagnosis of lupus erythematosus. The history of complete disappearance of the lesions had been elicited. It was difficult to account for this occasional disappearance.

Sarcoid, as was well known, disappeared, though if a reasonably large lesion it was likely to leave some deep atrophy. Evidently this man's former attacks had not left any atrophy.

MANHATTAN DERMATOLOGICAL SOCIETY

Regular Meeting, May 14, 1918

HOWARD FOX, M.D., *Chairman*

TINEA CIRCINATA VESICULOSA. Presented by DR. WEISS.

The patient was a boy who had had the eruption since the age of 4 years. There was scaling of the lesions which were serpiginous in shape, and which involved the ankles and flexors of the fingers. The speaker considered the eruption to be tinea circinata vesiculosa exhibiting the characteristic dysidrosis with infected vesico-bullae. This was the type of ringworm of the hands and feet described by Ormsby and Mitchell when the mycotic element joined the vesiculous one.

DISCUSSION

DR. PISKO considered the case to be eczema.

DR. WISE said it was extremely difficult to say whether it was an eczema or tinea, although he was in favor of the former. It would be impossible to make a differential diagnosis without a culture.

DR. GILMOUR diagnosed the case as eczema.

DR. SATENSTEIN said we had heard so much of tinea of the hand that when we could not make any other diagnosis we called conditions tinea, without any actual microscopic proof.

DR. WEISS said he would make cultures and report at the next meeting, in the fall. The demonstration of the fungi, however, was a very difficult one, especially when secondary infection had taken place.

CASE FOR DIAGNOSIS. Presented by DR. WEISS.

The patient, a young lady, presented an area of minute punctae in clusters on the chin. The condition had been present three years and presented a purpura-like appearance. The lesions did not disappear under pressure and apparently were punctate hemorrhagic lesions.

DISCUSSION

DR. WISE said it was very difficult to make a diagnosis in this case with artificial light. The patient had acne, seborrhea oleosa and a seborrheic patch on the chin which would be called rosacea if seen in an older woman. The speaker thought it was analogous to rosacea in an older person, on a seborrheic base.

DR. PISKO said if the condition was on the nose no one would hesitate to call it eczema rubrum nasi.

DR. WEISS said he first thought it was acne as there were acne lesions on the cheek, but when he found that the whole group was of a very small, slightly raised papular type, without vesiculation, and of a minute purpuric appearance, his diagnosis of acne became somewhat uncertain.

ANNULAR SYPHILID. Presented by DR. OCHS.

The patient, a negress, aged 22, had had a generalized annular syphilitic eruption two weeks before presentation, which involved the face, legs, arms, buttocks, and the back; in fact, it was generalized. The lesions all healed with hyperpigmentation around the location of the lesion and depigmentation within its area.

ANNULAR ATROPHIC LICHEN PLANUS. Presented by DR. GILMOUR.

The patient was a man, aged 28, born in the United States, a jeweler by occupation, who developed a small spot on the anterior aspect of the left forearm and also on the right leg, six weeks before presentation to the Society. The lesions had become papular and ringlike in appearance. They did not itch and had gradually spread over the body. On the left side of the mouth, near the tonsil, there was a bluish spot which was eroded. The speaker thought the lesions were the atrophic and annular form of lichen planus. The center of the ringed lesions, which were made up of polygonal papules, showed a distinct atrophy. A few outlying lesions showed a faint purple color, were angular and had somewhat depressed centers. The interesting fact was that the patient had no itching but appealed for treatment because he was rejected from the service on account of his skin condition.

LEUKONYCHIA. Presented by DR. WEISS.

The patient, a barber, aged 34, had an affection of all of the finger nails, which were well-shaped and snow-white. The discoloration started four years ago and spread gradually. The nails were extremely soft and showed a subungual hyperkeratosis under the free ends. The patient was bald and wore a wig. He presented anomalies of the nails with an atrophic condition of the hair which was frequently observed and showed an evolutionary defect and predisposition for diseases of the skin.

DISCUSSION

DR. GILMOUR said he thought it was hard to make a diagnosis of affections of the nails. He had a patient who came to the clinic in which the nails were undermined and there was scaly material under the nails, and if the patient had not had typical psoriasis he would not have known what to call the condition.

DR. OCHS said he thought the process was due to pushing back the cuticle with subsequent injury of the nail. It reminded him of a case he presented a few years ago, a young lady who had every nail affected, leukonychia striata. He obtained a history that she had been pushing the cuticle back and when this was discontinued the nails grew out and assumed a normal appearance.

DR. GILMOUR said he saw a patient in whom the appearance of the nails was similar to this one. It was treated with 10 per cent. ammoniated mercury ointment and the nails grew out quite normally. In his case the diagnosis of psoriasis was made by the presence of other lesions on the body.

DR. WEISS said the man was bald and this might have something to do with his resistance to treatment. Also his occupation might have something to do with the condition. A local nail affection not depending on psoriasis, tinea, or some other affection, was most likely based on a deficient internal secretion influencing the normal evolution of the adnexa. The speaker said he would like some suggestions regarding the treatment of this case.

DR. WISE said he had two similar cases and nothing but prolonged roentgen-ray treatment did any good. The patients finally recovered.

SENILE KERATOSIS OF THE NOSE AND PEDUNCULATED SEBACEOUS CYSTLIKE GROWTH OF THE FOOT. Presented by DR. PAROUNAGIAN.

H. R., a man, aged 46, born in the United States, was a salesman by occupation. He had two small lesions on the nose of four years' duration which were senile keratotic in type. There were no subjective symptoms. He presented on the right foot, 1 inch below the external malleolus, a silver quarter-sized growth which was pedunculated, red, scaly, with round borders, fairly soft and not painful. He gave a history of having a wartlike growth after which it began to grow and the pressure of the shoe produced a mushroom-like appearance. He also had a small wartlike growth on the left foot.

DISCUSSION

DR. GILMOUR diagnosed the case as fibroma.

DR. WISE made a diagnosis of epithelioma.

DR. SATENSTEIN said the condition was common on the ear of athletes and usually followed a hematoma. This patient probably had had a hematoma. The case was similar to one presented by Dr. Ochs. The speaker advised excision of the lesion.

DR. GILMOUR said the patient told him he had not had a history that would indicate that he had ever had a hemorrhage that resulted in a hematoma. He thought the condition did not in any way resemble that known as cauliflower ear.

DR. PAROUNAGIAN said he presented the case with the diagnosis mentioned to bring out discussion. He would excise the tumor and depend on the microscope for diagnosis.

FUNGATING EPITHELIOMA. Presented by DR. OCHS.

The patient was an adult woman, aged 40, who had been seen by the exhibitor for the first time the day before presentation to the Society. She presented on the anterior surface of the left leg an outgrowth of one year's duration. She had had no pain nor any subjective symptoms. She stated that she had struck herself on the fire-escape while putting out wash. The exhibitor expected it to be the beginning of an epitheliomatous degeneration. The papillomatous outgrowth was about 2½ inches long and about 1 inch in diameter. At its base it was narrower than in its center, was soft to the touch, and hung down parallel to the leg. Its distal end showed blood crusts and had slight induration which prompted the diagnosis of epithelioma.

TUBERCULOSIS OF THE THROAT. Presented by DR. PAROUNAGIAN.

The patient, Joseph B., Russian, aged 54, a tailor by occupation, was from the Gouverneur Clinic. His father died at the age of 72 from diabetes; his mother was living, aged 75, and in good health. He had had a cough for the past ten years. He denied a venereal history and the Wassermann and tuberculin tests were both negative, as was also an examination of the lungs. The condition of the throat consisted of extensive superficial ulceration involving the left tonsil and the greater portion of the pharynx extending toward the right side. It was not painful, and according to the patient's statement had been present about four or five weeks. No glandular swelling was present.

REPORT ON CASE PRESENTED FOR DIAGNOSIS AT LAST MEETING. DR. OCHS.

DR. SATENSTEIN reported on the microscopic findings in the case of the young man with nodules on the face. One of the nodules was excised and found to be a very active basal cell epithelioma. The diagnosis of benign cystic epithelioma had been made by Dr. G. H. Fox, and some one suggested sarcoid and tuberculosis. Epithelioma had also been suggested.

DR. OCHS said he presented the case as one of epithelioma but had never seen one as prolific as this case. As near as he could remember there were over seventy-five lesions scattered over the face.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Feb. 20, 1918

DAVID LIEBERTHAL, M.D., *President*

LICHEN PLANUS. Presented by DR. HARRIS.

The patient was a woman, aged 54 years, who presented a lesion of the tongue which had been present for six months. The lesion was a noninfiltrated, oval plaque on the left side of the anterior part of the dorsum of the tongue. There was a somewhat cleared area in the center which gave it a bull's eye appearance.

DISCUSSION

DR. MCEWEN said he did not know what the tongue condition was. The woman impressed him as being either a nephritic or the victim of recent hemorrhage.

DR. QUINN had thought of lupus erythematosus in connection with the case.

DR. PUSEY was convinced that it was a case of lichen planus limited to the mouth.

DR. HARRIS said his diagnosis was lichen planus, but the case had been sent to him as carcinoma of the tongue. He found one circinate patch on the right cheek and later another patch appeared below. He believed it was a typical lichen planus. The anemia was due to the fact that the patient had been living under poor conditions and was despondent. She was now receiving protiodid of mercury. The lesion was an annular patch of lichen planus. The patch on the cheek had a definitely elevated edge.

HYDROA VACCINIFORME. Presented by DR. SHAFFNER.

The patient was a boy, aged 10, who had an eruption of four years' duration which recurred in the summer, usually clearing up in winter but leaving scars. He had a very mild attack this winter at the height of the blizzard. Scars

were present on the face, including the nose, where a moderate atrophy existed; scars were also present on the backs of the hands and the lower forearms. The mother stated that the eruption consisted of vesicles and large bullae. Extreme heat even with full protection of the skin had provoked severe attacks in the past summers.

LICHEN CHRONICUS, VIDAL. Presented by DR. LIEBERTHAL.

The patient was a lady, aged 45, who had always enjoyed good health and never been subject to any skin disease. The present condition began on the neck about a year ago in the form of a dry, itchy patch and had gradually increased to its present size. No other part of the body was affected.

DISCUSSION

DR. PUSEY considered it a lichen planus and thought the patch was too small and the individual lesions were too big for the lichen simplex chronicus. It was only in one patch on one side of the neck. The lesions were like minute keloids and had the color of lichen planus. He believed it was not necessary for the lesions to become general and that a microscopic section should be made to settle the diagnosis.

DR. LIEBERTHAL said his opinion was based not only on the appearance of the lesion, but also on the fact that the skin was itchy before any lesion occurred; furthermore, that in over a year no other parts of the skin showed lesions of lichen planus.

CASE FOR DIAGNOSIS. Presented by DR. HARRIS.

The patient was a negress, aged 35, married, who had an eruption on the arms, palms and back, which had been present for two years. The eruption consisted of erythematous papules which came out in groups, underwent involution in the center and left an atrophic scar which was somewhat scaly. There was no evidence of ulceration at the time of presentation.

DISCUSSION

DR. STILLIANS said he had seen the case two weeks previously and tried to make a tuberculid out of it but could not, because of the lack of evidence of central necrosis or increased pigmentation. He thought it was a diffuse lupus erythematosus.

DR. FOERSTER believed it was a papulo-necrotic tuberculid.

DR. PUSEY agreed with Dr. Foerster and wanted to know what Dr. Harris found about the glands. He thought lupus could not be entirely ruled out on account of the lesions on the hands.

DR. HARRIS believed it was a lupus erythematosus and that the lesions on the hands were typical of that disorder. The patches were covered with a scale but there was no evidence of necrosis. He had taken a section from the middle of a lesion and this showed flattening of the epidermis with almost no infiltration.

DR. MCEWEN thought the scars were rather deep and punched out for those of lupus erythematosus and that a patient with such an extensive case of that disorder would probably have died before reaching the present stage.

DR. FOERSTER had never seen a case of lupus in a colored person which had not shown a great amount of loss of pigment.

DR. HARRIS thought if the case was seen six months later the loss of pigment would be present. There were no crusts at all, just scales and not such as would be found in a tuberculid.

CHEILITIS GLANDULARIS. Presented by DR. WAUGH.

The patient was a man, aged 60, who had had the disorder one and one-half years. There was an oval-shaped, reddened, moderately tender and slightly indurated lesion involving one-third of the vermilion border of the lower lip. It began as a reddened area on the mucosa, which spread gradually. There had been moderate tenderness since the onset. The surface presented numerous pinhead and slightly larger yellowish crusts, which when removed, revealed small openings from which a yellowish viscid material would be expressed.

The margins of the lesion were sharply defined, and the mucosa showed a purplish red areola surrounding the affected area. The lesion extended to, but did not involve, the cutaneous part of the lower lip. A small, pea-size, firm, painless nodule could be felt beneath the mucosa, near the affected area. The submaxillary glands could not be palpated.

DISCUSSION

DR. MCEWEN thought it was an epithelioma of the lip.

CASE FOR DIAGNOSIS. Presented by DR. HARRIS for DR. ZEISLER.

The patient was a Japanese student, aged 25, who had white lines on the hips which he claimed had appeared three or four years previously. At the time of presentation the patient showed many linea albicantes.

PITYRIASIS ROSEA. Presented by DR. STILLIANS.

The patient was a young woman, aged 16, a factory worker, who entered the hospital a month before presentation with a slight eruption on the shoulders and neck and upper arms. The original eruption had cleared up and at the time of presentation there were only a few lesions left. There was only very slight itching.

The original eruption consisted of oval patches, scaling at the borders and one or two clearing at the center; they were very slightly elevated, of a chamois color, distributed fairly symmetrically over the shoulders, front of the chest and upper arms. As the eruption began to clear new lesions appeared, pinkish maculo-papules, a few of which were present at the time of presentation. The Wassermann reaction was negative. The case was shown because of its chronicity.

DISCUSSION

DR. HARRIS said that when he first saw the case it looked like a maculo-papular syphilis. The patient was put on treatment but the lesions did not clear up.

DR. STILLIANS stated that the original lesions had cleared up under a zinc paste with benzoic and salicylic acids.

DERMATITIS STAPHYLOGENES. Presented by DR. MCEWEN.

The patient was a man, aged 38, who had scratch marks over the entire body. The patient said he had been scratching for three months. The lesions around the genitalia had been present for two or three months. He denied alcoholism and venereal infection. The Wassermann reaction was negative.

The second patient (Goldie) was the same young woman who had been exhibited at two previous meetings. The dermatitis consisted of seborrheic pustular growths which involved the region around the ears, the groins, the flexors, and was very profuse in the genital region. She had improved wonderfully under autogenous vaccine, but there had been a recurrence which had not yet subsided.

DISCUSSION

DR. PUSEY believed the man's dermatitis was due to irritation of some sort —he might have been working in lime or it might have been just dirt—and he had a pus infection. He saw no reason to regard the pus infection as the primary factor. He was such a skeptic about vaccines that he was very slow to accept the idea of vaccine curing these cases. He thought the fact that the patient had been in the hospital and properly taken care of accounted for the improvement rather than the vaccine.

DR. STILLIANS thought that vaccines were not always specific. They acted as foreign proteid and produced effects broader than an increase of resistance to the organisms of which they were made. He did not like to accept a cure from a vaccine as very valuable evidence that the disease was due to the particular germ contained in the vaccine.

DR. QUINN thought Dr. McEwen was on the right road to try to simplify a great many things. He was sure that he had seen the same organism produce lesions differing in character and believed this was a move in the right direction.

DR. PUSEY thought the rôle of pus organisms in these diseases after they once became started was rather important. There might be a focus of infection as the result of some sort of insult to the skin and there was a dermatitis as a result. In the case of the man he would depend on getting him cleaned up in the ordinary sense of the term.

DR. POTTHOFF thought it was a pus infection.

DR. HARRIS could not see any evidence of pus infection. He thought the improvement under vaccine therapy was due to the fact that the vaccine changed the chemistry of the body in some way, but not necessarily in a specific manner.

DR. LIEBERTHAL thought there probably was some systemic derangement which was keeping the dermatitis so stubborn. He had seen some good results from tuberculin in similar instances.

LEPRA. Presented by DR. HARRIS.

The patient was a man, aged 29, a Greek, who had been in this country one and one-half years, coming from the Island of Samos. For over a year he had shown papular lesions of the face and the upper extremities, some of which had become necrotic, leaving pigmented scars. From the necrotic lesion as well as in the excised papules the bacillus of Hansen was readily demonstrated.

ACNE ROSACEA IN A SYPHILITIC, WITH ACTIVE SYPHILITIC LESION. Presented by DR. MCEWEN.

The patient was a man, aged 60, who presented an eruption of the face which had been present for six weeks. The lesions were symmetrical, and consisted of hard, multiple papules and pustules on an erythematosus background. There was a history of chancre seventeen years ago, the Wassermann reaction was positive and the patient had received some mercurial treatment. He was presented as a good illustration of the occasional necessity of differentiating between rosacea and syphilis.

DISCUSSION

DR. LIEBERTHAL thought the lesions were unquestionably syphilitic, not rosacea.

DR. MCEWEN thought the lesions on the cheek were those of rosacea and not of syphilis and that the syphilis was in the background, without present clinical manifestations. The patient had been on antisyphilitic treatment for only three or four days.

GROUPED PAPULO-SQUAMOUS SYPHILIS. Presented by DR. HARRIS.

The patient was a man, aged 23, who presented lesions of the shoulder, throat and lip which had been present for a year. He had had syphilis for eleven months and for about four months had had the eruption which he exhibited. He also showed a large mucous patch of the upper lip and left tonsil. The Wassermann reaction was positive.

DISCUSSION

DR. HARRIS stated that the man had been receiving treatment for eleven months, ever since he had the first lesion.

ATROPHIA MACULOSA ET STRIATA. Presented by DR. QUINN.

The patient was a man, aged 50, Polish. He presented marked varicosity of the veins of the lower extremities and also marked atrophy of the skin of the legs and arms with erythematous spots with hyperemic capillaries, terminating in scars.

DISCUSSION

DR. HARRIS thought it was a case of acrodermatitis atrophicans.

DR. MCEWEN asked why it could not be called an idiopathic atrophy.

DR. PUSEY believed it was a poor plan to give a specific name to a lesion like that. The man had an atrophy of the skin as the result of his varicose veins and the secondary changes had come from passive hyperemia and inflammation. The man probably had poor material in his veins to start with and the changes in the skin were secondary to that. So-called atrophy of the skin came from a good many chronic conditions of the skin—from chronic dermatitis of the legs, for example. He considered the condition in this case just a terminal stage of another process and thought the essential process was a failure of the vascular system in the legs.

DR. HARRIS said that a good deal of the varicosity was apparent rather than real and it affected the lower extremities much more than the upper.

DR. STILLIANS agreed with Dr. Harris that it was a form of chronic atrophy that affected the extremities instead of the body. There was another form which appeared in various places and became disseminated, involving trunk and limbs. In the former type the lesions only went to the buttocks and then stopped.

TINEA SYCOSIS. Presented by DR. MCEWEN.

The patients were both men, aged about 25 and 30, respectively. One of them was a hostler and the other drove an express wagon. The lesions were typical of tinea barbae and the diagnosis had been confirmed microscopically. They were shown as classic examples of a relatively uncommon skin disorder.

Correspondence

FOLLICULITIS ULERYTHEMATOSA RETICULATA

To the Editor:—The writer sincerely regrets that Dr. Charles J. White's article "Nevus Follicularis Keratosis," published in THE JOURNAL OF CUTANEOUS DISEASES, March, 1914, was inadvertently overlooked while searching the literature for cases resembling the disease published under the heading of "Folliculitis Ulerythematosa Reticulata," by Dr. Parounagian and the writer, in THE JOURNAL OF CUTANEOUS DISEASES, June, 1918.

While the writer does not believe that the two conditions are of the same clinical entity, others may have the opposite opinion. Furthermore, there are histologic similarities which make it advisable that future investigations of folliculitis ulerythematosa reticulata should include White's nevus follicularis keratosis.

In response to an invitation Dr. White has kindly enumerated the similarities and dissimilarities between the two diseases. They are as follows:

They are both examples of follicular keratosis. They both show intradermal cysts and these cysts contain stratified keratin. The follicular orifices in both instances are dilated and plugged with keratin. There is little inflammatory reaction—less in Dr. White's case than in ours. His case does not end in scarring—ours does. His case was congenital—ours might have been. Dr. White does not say that the two conditions are the same but believes that they are similar and that they might prove to be the same.

The writer agrees with the above mentioned similarities with the exception of the inflammation. In our cases, in places there was a pronounced infiltration and all through the sections the blood vessels and lymph spaces were rather markedly dilated. They even contained coagulated serum and red cells. Also there was some modification of the vessel walls. It was not proved whether the inflammation was primary or secondary. It must be admitted, however, that the difference in these probable secondary changes are unimportant.

Admitting the similarities, there are several important histologic points in our cases not found in Dr. White's patient. The writer refers particularly to the budding processes from the follicles, some of which developed into horn cysts, others into cell-nests, while still others seemed to be abortive attempts at sebaceous gland formation. Histologically, in our cases, there was a distinct degeneration of collagen with subsequent retraction of the derma. The sebaceous glands were decidedly undeveloped. The writer does not desire, however, to separate the two conditions because of these differences in histologic details. This indeed would be a risky undertaking. It is on clinical grounds that the two conditions are most strikingly dissimilar. In Dr. White's case there was a bandlike lesion extending around the side of the trunk and containing enormous follicular orifices, many of which contained a plug resembling a very large comedo. The general appearance was crateriform and sievelike. The skin throughout the band was thickened—it appeared to be deeply infiltrated on palpation. The secondary lesions consisted of boils and scars from former furuncles and in one place there was an indurated mass that was thought to be cancerous. The eruption was said to have begun at the age of 8 or 10 years and was progressive up to the time the report was made.

This clinical description does not fit our cases at all. In all the cases reported as folliculitis ulerythematosa reticulata the clinical symptoms were identical. The eruption began at about the age of 8 years and was progressive

until late adolescence when it began to subside and in adult life there might be very little evidence of the former trouble. The eruption was bilateral, absolutely symmetrical and was limited to the cheeks. There was a well marked erythema throughout the affected area. The general appearance was that of reticulation and this was due to tiny areas of retraction (atrophy) alternating with ridges that were on a level with the niveau of the skin. There were no gaping follicles and no enormous plugs (clinically). A few "comedones" could be seen with the unaided eye; while with a lens, follicular plugs could be detected both in the ridges and the retracted areas. There were no secondary lesions such as pustules, papules, furuncles, etc. The skin did not feel thickened.

Dr. White separates his case from nevus sebaceous and nevus acneiformis unilateralis because the sebaceous system was not involved. In our cases the sebaceous system was involved as evidenced by fat in many of the horny plugs as well as by the histologic evidence already mentioned. One does not hesitate to agree that Dr. White's case represents a nevus but in the same sense one hesitates to employ the word nevus in our cases.

While admitting that there is much in common between the two conditions the writer cannot, at the present moment, accept them as being the same although they both can be placed, perhaps, in that large group known as the congenital keratodermata in which there are many clinical entities.

GEORGE M. MACKEE.

BOOK REVIEWS

ROENTGENOGRAPHIC DIAGNOSIS OF DENTAL INFECTION IN SYSTEMIC DISEASES. By Sinclair Tousey, A.M., M.D., Consulting Surgeon, St. Bartholomew's Clinic, New York. New York: Paul B. Hoeber, 1916.

This booklet contains seventy-five pages, including the introduction and the index. The subject matter is based almost exclusively on some of the author's previous contributions on the same subject, with elaborations and about fifty illustrations. The little bibliography at the end of the book unfortunately is comprised of but one writer's works—the author's; hence the reader is bound to get a rather one-sided view of the subject, and after perusal of the booklet he may entertain a pardonable curiosity with respect to the opinions and experiences of other workers in the same field of medicine. The author submits numerous case reports, many of them fragmentary and incomplete. Trivial errors are numerous, but readily amenable to correction. For example, the author mentions a case of "tubercular" peritonitis and "tuberculous" pleurisy, occurring simultaneously in one patient. The difficulty of choice between the personal pronoun, "I" and the words, "the author," is somewhat painfully evident throughout the monograph.

The photographic illustrations, taken as a whole, are poor. The paper and printing, on the other hand, are excellent. M. S.

ORAL SEPSIS IN ITS RELATIONSHIP TO SYSTEMIC DISEASE. By William W. Duke, M.D., Ph.B., Kansas City, Mo. Professor of Experimental Medicine in the University of Kansas School of Medicine; Professor in the Department of Medicine in Western Dental College; Visiting Physician to Christian Church Hospital; Consulting Physician to Kansas City General Hospital, Kansas City, Mo., and to St. Margaret's Hospital, Kansas City, Kan. With 170 illustrations. St. Louis: C. V. Mosby Company, 1918.

A general survey of this book at once gives the reader the pleasant impression that it is the work of a careful and conscientious observer, and that the author's observations and opinions are based on a thorough acquaintance with the scientific aspects of oral infection and its influence on the general metabolism. The book comprises eight chapters, captioned as follows: Introduction; pyorrhea alveolaris; alveolar abscesses; metastatic infection; nonrelated infection as influenced by oral sepsis; toxic effect of oral sepsis; headache as related to oral sepsis; summary and conclusions. These chapters make good reading and will prove of interest to general practitioner as well as specialist. References and case reports dealing with acne, furunculosis and other pyodermias will interest the dermatologist, who stil has a great deal to learn about the influence of oral sepsis on the causation of many cutaneous diseases.

A complete, up-to-date bibliography is appended, greatly enhancing the value of the book. The photographic illustrations are well reproduced.

The work contains 124 pages, is well printed on fine paper and has a good binding. M. S.

SYPHILIS AND PUBLIC HEALTH. By EDWARD B. VEDDER, A.M., M.D., Lieutenant-Colonel, Medical Corps, U. S. Army. Published by permission of the Surgeon-General, U. S. Army. Cloth, 315 pages. Price, $2.25. Philadelphia and New York: Lea and Febiger, 1918.

This book is very timely in its appearance; the importance of solving the venereal problem in civil and military life, being one of the questions of the hour. The author's logical and sober views of all the efforts in this direction are the result of a large experience and therefore of more than ordinary value.

The incidence, transmission and prevention of venereal diseases are very ably discussed in the light of our present knowledge; special stress being made of points of interest to sanitarians and public health workers.

Practitioners in or out of military service will find the book worth while reading. An extensive bibliography with a subject and authors' index makes the book a handy reference volume. E. W. A.

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